HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
MARCH 27, 2013
APPLICATION SUMMARY

NAME OF PROJECT:	Baptist Memorial Rehabilitation Hospital
PROJECT NUMBER:	CN1212-061
ADDRESS:	1238 and 1280 South Germantown Parkway and adjacent property at an unspecified address Germantown (Shelby County), TN 38138
LEGAL OWNER:	Baptist Memorial Rehabilitation Hospital, G.P. 5250 Virginia Way, Suite 240 Brentwood (Shelby County), TN 32027
OPERATING ENTITY:	CHC Management Services, LLC 5250 Virginia Way, Suite 240 Brentwood (Shelby County), TN 32027
CONTACT PERSON:	Arthur Maples (901) 227-4137
DATE FILED:	December 14, 2012
PROJECT COST:	$33,167,000
FINANCING:	Cash Reserves of Centerre Healthcare
PURPOSE FOR FILING:	Establishment and construction of a forty-nine (49) bed rehabilitation hospital

DESCRIPTION:

Baptist Memorial Rehabilitation Hospital is seeking approval for the establishment of a forty-nine (49) bed rehabilitation hospital to be constructed at 1238 and 1280 South Germantown Parkway, Germantown (Shelby County), TN. If approved, Baptist Rehabilitation Hospital-Germantown will de-license the forty-nine (49) bed rehabilitation unit from its 50-bed hospital located at 2100 Exeter Road, Germantown (Shelby County), TN. Baptist Rehabilitation Hospital-Germantown is approximately 2.5 miles from the proposed new facility.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

   The applicant determined the proposed service area inpatient rehabilitation bed need by using population statistics from the Tennessee Department of Health.

   It appears that this criterion has been met.

2. The need shall be based upon the current year's population and projected four years forward.

   The population of the proposed service area (Shelby County) is 956,126 in 2013 and 983,298 in 2017. At the rate of 10 beds per 100,000 population, the need is 95 beds in 2013 and 99 in 2017. There are currently 219 licensed rehabilitation beds in Shelby County resulting in a current surplus of 124 licensed rehabilitation beds in Shelby County.

   It appears that this criterion has not been met.

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services.

   Over 70% of the current patients at Baptist Rehabilitation Germantown reside in Shelby County.

   It appears that this criterion has been met.

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.

   The criterion is not applicable.

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds,

   The applicant is applying for the establishment of forty-nine (49) licensed inpatient rehabilitation beds that will be located in a freestanding rehabilitation hospital.

It appears that this criterion has not been met.

NOTE TO AGENCY MEMBERS: Pursuant to TCA § 68-11-1607 (g), a hospital with fewer than one hundred beds may increase its total number of licensed beds by ten beds over any one year period without obtaining a certificate of need.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit	– 75%
31-50 bed unit/facility	– 80%
51 bed plus unit/facility	– 85%

According to 2011 Joint Annual Report data, there are two (2) licensed 20-30 bed units/facility's in the service area with an average occupancy of 59%, one in the 31-50 bed category at 94% and two in the 51 plus category at 57.6%.

It appears that this criterion has not been met.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.

The applicant has access to employed professionals that currently staff the existing forty-nine (49) bed Baptist Rehabilitation Germantown facility.

It appears that this criterion has been met.

SUMMARY:

Baptist Memorial Health Care and Centerre Healthcare have formed a joint venture to construct a new modern free-standing forty-nine (49) bed inpatient rehabilitation hospital. Baptist Memorial Rehabilitation Hospital will be licensed separately from the existing freestanding 50-bed Baptist Rehabilitation-Germantown hospital. If approved, Baptist Rehabilitation-Germantown will de-license forty-nine (49) inpatient rehabilitation beds from its 50 bed hospital leaving it with 1 medical surgical bed. The proposed rehabilitation hospital will be located 2.5 miles away from BRG and will continue to serve Shelby County residents. Historically more than 70% of

Baptist Rehabilitation-Germantown inpatient rehabilitation admissions resided in Shelby County.

NOTE TO AGENCY MEMBERS: If this application is approved, both the applicant and the existing Baptist Rehabilitation-Germantown hospital will meet the previously discussed 10-bed exemption requirement found under T.C.A. § 68-11-1607 (g).

The applicant indicates BRG currently offers a comprehensive array of inpatient rehabilitation services. The forty-nine bed rehabilitation unit operates in twenty-one (21) semi-private rooms and seven (7) private rooms. The applicant states a new facility is needed to better align patient services with patient needs and expectations. The applicant states improvements to BRG are not feasible.

The applicant indicates BRG will continue to provide outpatient rehabilitation services and one (1) medical/surgical bed in the existing hospital and also continue to operate its existing separately licensed eighteen (18) bed skilled nursing home. This facility previously was licensed as a sixty-eight (68) bed hospital but was approved under CN1001-004A at the April 28, 2010 Agency meeting to convert eighteen (18) rehabilitation beds to eighteen (18) Medicare skilled nursing beds.

In the supplemental response, the applicant indicated plans are still in process regarding the future use of the forty-nine (49) inpatient rehabilitation unit space at Baptist Rehabilitation-Germantown. One possibility under consideration is to seek Certificate of Need approval to relocate a thirty-five (35) bed skilled nursing home located at Baptist Memorial Hospital-Memphis to BRG. The thirty-five bed facility was approved for inactive status by the Tennessee Department of Health, Board for Licensing Health Care Facilities on February 7, 2013.

The **new facility** will focus on providing inpatient rehabilitation services only. It will have added features and additional space that allows for expansion of services and program enhancements. The applicant emphasizes the new facility will be comprised entirely of private rooms of approximately 285 square feet. The forty-nine ADA (American Disabilities Act) compliant private rooms (with private bathrooms) will increase utilization by eliminating the problems of matching appropriate patients in semi-private rooms due to gender and disease control issues. Research articles and studies are included in the supplemental response on pages 21-26 that support single bed rooms. In addition, there will be a mobility courtyard that simulates curbs, rough and smooth surfaces and various depths of steps. A larger therapeutic gym will be available for therapeutic exercises and training.

The applicant indicates a "Center of Excellence" will be available consisting of specialized programs for stroke, neurological disorders and brain injury patients. The applicant states a specialized Stroke/Neurological Unit consisting of 24-26 beds will be available to meet the needs of patients being discharged from inpatient facilities. The specialized unit will be self-contained, including dedicated therapy and treatment space. In addition, the applicant states specialized programming, beds and monitoring equipment will be offered to brain injury patients. The applicant indicates the ability to care for medically complex patients will reduce the likelihood of readmissions and as a result reduce the overall cost of care.

The applicant will apply to be CARF (Commission on Accreditation of Rehabilitation) accredited for the treatment of stroke and brain injuries. CARF is an independent, nonprofit organization that focuses on advancing the quality of services and evaluating healthcare providers' commitment to continually improving services and the community. In the supplemental response, the applicant states Baptist Rehabilitation-Germantown is the only provider in Memphis that has achieved accreditation for Stroke and Brain Injury.

Baptist Memorial Health Care Corporation is a system that includes fourteen (14) hospitals, home health and hospice agencies, minor medical clinics, behavioral health programs and a network of surgery, rehabilitation and other outpatient centers. Centerre Health Care Corporation, based in Brentwood Tennessee, is a national provider of inpatient acute rehabilitation services incorporated in 1999 dedicated to partnering with medical centers. A description of Centerre Health's joint venture partnership philosophy, executive management team and business model is located on page 6-12 of the supplemental response.

The ownership of the proposed new hospital will consist of a 55% ownership interest of Baptist Memorial and 45% of Centerre Healthcare. A board of Directors consisting of members from both parties will govern the new hospital and will ensure that Baptist Memorial Health Care Corporation's Ethical and Religious Directives and Charity Policies will be followed. A description of the ownership structure is located in Attachment A-4. A third party developer will purchase and develop the land and building and lease it back to the joint venture.

Note to Agency Members: Baptist Memorial Rehabilitation Hospital will seek Medicare certification as an Inpatient Rehabilitation Facility. To be excluded from the Acute Care Hospital Inpatient PPS and instead be paid under the IRF (Inpatient Rehabilitation Facility) PPS, an inpatient rehabilitation hospital or rehabilitation unit of an acute care

hospital must meet the requirements for classification as an IRF. One criterion Medicare uses for classifying a hospital or unit of a hospital as an IRF is that a minimum percentage of a facility's total inpatient population must meet at least one of 13 medical conditions listed. This minimum percentage is known as the compliance threshold. Beginning July 1, 2006, the Medicare, Medicaid, and SCHIP Extension Act of 2007 stipulated that the compliance threshold should be set no higher than 60 percent. Currently, the regulatory requirement is known as the "60 percent rule." Source: CMS Payment System Fact Sheet retrieved from http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network on March 5, 2013.

The 13 medical conditions that qualify for the 60 percent rule, as specified in the May 7, 2004, final rule, are:

Stroke;
Spinal cord injury;
Congenital deformity;
Amputation;
Major multiple trauma;
Fracture of femur (hip fracture);
Brain injury;
Neurological disorders, including: Multiple sclerosis;
Motor neuron diseases;
Polyneuropathy;
Muscular dystrophy; and
Parkinson's disease; and
Burns.

The applicant has provided a table on page 36 of the supplemental response that projects utilization in Year One and Year Two of the thirteen qualifying medical conditions as defined by CMS as part of the 60 percent rule. The applicant projects over 65% of patients will have a diagnostic category of either a stroke or neurological condition. Stroke patients are projected to represent 325 cases and neurological patients 190 cases of the projected 785 total cases in Year One.

According to the Joint Annual Report, the licensed and staffed hospital bed occupancy at Baptist Rehabilitation-Germantown was 48.3% and 60.4%, respectively in 2011. The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

Licensed Beds- The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken

down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).

Staffed Beds-The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.

According to population projections published by the Tennessee Department of Health, the 2013 population for Shelby County is estimated at 956,126 residents. By 2017, the service area is projected to grow by 2.7%, to 983,298. Residents who are age 65 and over currently compose 10.8% of the general population. By 2017, the 65 and over cohort are projected to grow 12.5% to 118,044 persons, or 10.5% of the general population. According to the Bureau of TennCare, enrollees represent 24% of the general population in Shelby County compared to 18.8% statewide.

Besides the applicant there are four other facilities which provide inpatient rehabilitation services to the service area. The service area-wide licensed occupancy has averaged 66.2% and the average daily census 30.0 over the last three historically reported years. The number of licensed beds decreased from 237 in 2009 to 219 in 2011.

NOTE TO AGENCY MEMBERS: The decrease in licensed rehabilitation beds in the Shelby County service area from 2009 to 2011 is a result of BRG's decision to convert eighteen (18) hospital rehabilitation beds to skilled nursing home beds (approved under CN1001-004A at the April 28, 2010 Agency meeting.

The following table indicates the inpatient rehabilitation licensed occupancy in Shelby County has declined from 69.5% in 2009 to 65.4% in 2011. Per Guidelines for Growth Criteria and Standards for Comprehensive Inpatient Rehabilitation Services, additional inpatient rehabilitation beds should not be approved by the Agency unless all existing units or facilities are utilized at the follow levels: 20-30 bed unit at 75% occupancy, 31-50 bed unit/facility at 80% occupancy and 51 bed plus unit/facility at 85% occupancy. As reflected in the following table, two of the five existing inpatient rehabilitation facilities in Shelby County exceeded occupancy standards to add additional rehabilitation beds. HealthSouth Rehabilitation of North Memphis (40 beds) and the Regional Medical Center at Memphis' (20 beds) occupancy levels in 2011 were at 93.5% and 95.8%, respectively. There were three existing inpatient rehabilitation facilities that did not meet occupancy standards to add additional rehabilitation beds to the proposed service area. HealthSouth Rehabilitation of Memphis (80 beds), Saint Francis Hospital (29 beds) and Baptist Rehabilitation Germantown's (49 beds) occupancy standards were 66.9%, 21.7% and 49.3% respectively.

Shelby County Inpatient Rehabilitation Bed Capacity and Usage, 2009-2011

		2009	2010	2011	Occupancy Standard Met?
HealthSouth Rehab of Memphis	Licensed Beds	80	80	80	
	Average Daily Census	54.9	54.5	53.5	
	Licensed Occupancy	68.7	68.1%	66.9%	No
HealthSouth Rehab of North Memphis	Licensed Beds	40	40	40	
	Average Daily Census	33.7	35.9	37.4	
	Licensed Occupancy	84.3%	89.8%	93.5%	Yes
Saint Francis Hospital	Licensed Beds	29	29	29	
	Average Daily Census	12.4	6.2	6.3	
	Licensed Occupancy	42.8%	21.2%	21.7%	No
Regional MC at Memphis	Licensed Beds	20	20	20	
	Average Daily Census	19.8	19.7	19.2	
	Licensed Occupancy	99.2%	98.5%	95.8%	Yes
Baptist Rehabilitation-Germantown	Licensed Beds	68	68	49	
	Average Daily Census	35.8	28.2	24.2	
	Licensed Occupancy	52.7%	41.4%	49.3%	No
Total Rehabilitation	**Licensed Beds**	**237**	**237**	**219**	
	Average Daily Census	**33.1**	**28.9**	**28.1**	
	Licensed Occupancy	**69.5%**	**63.8%**	**65.4%**	

Baptist Memorial Rehabilitation-Germantown's inpatient rehabilitation services staffed occupancy has averaged 47.8% over the past three reported years. The applicant projects its average daily census and staffed occupancy will grow to 30.4 patients/day and 62%, respectively in 2014 following completion of the proposed project. The average daily census is projected to be 41.0 patients/day and 83.7% staffed occupancy in 2015, the second year following project completion. The applicant points out the new modern freestanding rehabilitation hospital with specialized programs as well as private rooms will have a positive impact on the growth of the proposed project.

The applicant projects an average overall Gross Charge of $2,834 per patient day in the first year of operation, which after an average 58% deduction from revenue for contractual adjustments, charity care and bad debt, will yield an average Net Charge of $1,649 per patient day. The applicant projects an operating loss in Year One of ($375,997) and net operating income of $2,505,305 in Year Two of the proposed project.

The Medicare and Medicaid/TennCare payor mix is expected to average approximately 60.0% (or $18.86 million) and 4.0% (or $1,257,628) of gross operating revenues, respectively. Projected Charity Care expenses are estimated at $259,707 or, 1.2% of Gross Operating Inpatient Revenue in Year One.

The applicant projects the total paid staff will increase from 85.1 full-time equivalents (FTE) to 87.1 FTEs by the second year of operation. The applicant projects 61.5 nursing FTE's and 23.6 therapy FTE's in Year One. A chart detailing the proposed staffing pattern for the applicant is located on page 43 of the application. At maturity, the applicant anticipates the new hospital will require approximately 130 clinical and non-clinical total FTE's.

According to the Historical Data Chart, Baptist Rehabilitation Germantown's Hospital's profit for the last three reporting years has steadily increased. The applicant reported favorable net operating income/loss (NOI) after capital expenditures of ($4,687,595.00) in 2009; $384,132.00 in 2010; and $2,156,595.00 in 2011. Average annual NOI was favorable at approximately 14.6% of annual net operating revenue for the year 2011.

According to the applicant, the project will be funded by Centerre Healthcare's capital contribution to the joint venture. A letter dated October 24, 2012 from Centerre Healthcare's Chief Financial Officer attests to the availability of funds for the proposed project. Centerre Healthcare will be 45% owners of the joint venture and will contribute $7.04 million in cash to fund operations (working capital and equipment).

Centerre Health Corporation reported total assets of $61,783,635.00, including $27,758,331 in total current assets, for the period ending December 31, 2011. Total current liabilities were $11,737,186.00. The current ratio is 1.56:1. Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

The total estimated project cost is $33,167,900.00, including: Legal, Administrative and Consultant Fees - $49,500; Contingency Fund - $484,217; Fixed Equipment - $2,303,000; Facility Lease - $30,286,183 and CON filing fees $45,000.

The proposed project involves approximately 59,400 sq. ft. of new construction. The applicant estimates the cost of construction to be $15,423,804 or approximately $259.66 per square foot. The projected cost per square foot is

between the 1st quartile cost of $235.86/sq. ft. and the median cost of $274.63/sq. for new hospital construction projects between 2009 and 2011.

The applicant has submitted the required corporate documentation, real estate deeds, and management agreement with Centerre Healthcare. Staff will have a copy of these documents available for member reference at the Agency meeting. Copies are also available for review at the Health Services and Development Agency's office.

According to the Project Completion Forecast Chart, the applicant plans to have the proposed rehabilitation hospital operating by August 2014. Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied or pending applications or outstanding Certificates of Need for this applicant.

Baptist Memorial Rehabilitation Hospital is partially owned (55%) by Baptist Memorial Health Care Corporation of Memphis, Tennessee, which has financial interests in this project. Baptist Memorial Health Care Corporation has no other Letters of Intent or denied or pending applications.

Outstanding Certificates of Need

Baptist Memorial Hospital-Tipton d/b/a Baptist Center for Cancer Care, CN1211-057A has an outstanding Certificate of Need that will expire April 1, 2016. The CON was approved at the February 27, 2013 Agency meeting for the relocation of Baptist Center for Cancer Care (BCCC) from its approved site at 1238 and 1280 South Germantown Parkway, Germantown (Shelby County), TN 38138 to the building known as The Shops of Humphreys Center at 50 Humphreys Boulevard, Memphis (Shelby County), TN 38120. The proposed new location also includes space conveniently located in nearby buildings at 80 Humphreys Center and 6029 Walnut Grove Road. The Cancer Center project includes the relocation of a positron emission tomography (PET/CT) unit, initiation of linear accelerator services, and acquisition of major medical equipment and related assets currently owned and operated by Baptist Memorial Hospital-Memphis (BMHM). The project involves relocating from BMHM two (2) linear accelerators and other radiation oncology equipment along with the CyberKnife linear accelerator. One (1) of the existing linear accelerators to be relocated from BMHM will be replaced when installed at the BCCC. The PET/CT unit to be relocated to BCCC will be a replacement of the BMHT PET/CT currently located at 1945 Wolf River Blvd., Germantown (Shelby County), TN 38138. The hospital total Cancer Center space is approximately 153,200 square

feet. The project does not involve the addition of beds or any service for which a Certificate of Need is required. The estimated project cost is **$84,834,200.00**. *Project Status: This project was recently approved.*

Baptist Memorial Hospital for Women, CN1211-058A, has an outstanding Certificate of Need that will expire April 1, 2016. The CON was approved at the February 27, 2013 Agency meeting for the construction of an Emergency Department dedicated for pediatric patients and the initiation of Magnetic Resonance Imaging (MRI) services on the Baptist Women's campus. The project will involve 37,500 square feet of new construction. The project does not involve the addition of beds or any other service for which a Certificate of Need is required. The estimated project cost is **$14,105,241.00**. *Project Status: This project was recently approved.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA HEALTH CARE ORGANIZATIONS:

There are no other Letters of Intent, denied or pending applications for other service area health care organizations proposing this type of service.

Shelby County Health Care Corporation d/b/a Regional Medical Center, CN1208-037A, has an outstanding Certificate of Need which will expire on January 1, 2017. The CON was approved at the November 14, 2012 Agency meeting to convert ten (10) medical surgical beds to ten (10) inpatient rehabilitation beds, add three operating rooms (ORs) dedicated to outpatient surgery in the Turner Tower, and renovate and relocate medical surgical beds to the Turner Tower, one of the newer buildings on the MED campus built in 1992. The estimated project cost is **$28,400,000.00**. *Project Status: This project was recently approved.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

LETTER OF INTENT

2012 DEC 10 AM 9 30

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the The Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Shelby (County), Tennessee, on or before December 10 (Month / day), 2012 (Year), for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Baptist Memorial Rehabilitation Hospital, G.P., a general partnership consisting of Baptist Memorial Health Services, Inc., an affiliate of Baptist Memorial Health Care Corporation and CRH of Memphis, LLC, an affiliate of Centerre Healthcare Corporation

with an ownership type of partnership and to be managed by: CHC Management Services, LLC intends to file an application for a Certificate of Need

to establish a rehabilitation hospital consisting of 49 beds. The hospital will be located in approximately 59,400 sq ft of space to be constructed at 1238 and 1280 South Germantown Parkway, Germantown Tennessee 38138. The location is close to the intersection of Germantown Parkway and Wolf River Boulevard in Germantown, Tennessee. Simultaneously with the implementation of the new hospital, Baptist Rehabilitation Hospital- Germantown would delicense the 49 bed Rehabilitation unit located at 2100 Exeter Road Germantown, Tennessee 38138 which is approximately 2.5 miles from the new site. The project does not involve the addition of beds or any other service for which a certificate of need is required. The estimated project cost is $33,167,900.

The anticipated date of filing the application is: December 14, 20 12

The contact person for this project is Arthur Maples (Contact Name) Dir. Strategic Analysis (Title)

who may be reached at: Baptist Memorial Health Care Corporation (Company Name) 350 N. Humphreys Blvd (Address)

Memphis (City) TN (State) 38120 (Zip Code) 901 / 227-4137 (Area Code / Phone Number)

Arthur Maples (Signature) 12/7/2012 (Date) (E-mail Address)

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The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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COPY

Baptist Memorial Rehab. Hospital

CN1212-061

CERTIFICATE OF NEED APPLICATION

Baptist Memorial Rehabilitation Hospital, G.P.

December 2012

1. ***Name of Facility, Agency, or Institution***

Baptist Memorial Rehabilitation Hospital
Name

1238 and 1280 South Germantown Parkway and adjacent property at unspecified address
Street or Route

Shelby	Germantown	TN	38138
County	City	State	Zip Code

2. ***Contact Person Available for Responses to Questions***

Arthur Maples		Dir. Strategic Analysis	
Name		Title	
Baptist Memorial Health Care Corporation		Arthur.Maples@bmhcc.org	
Company Name		Email address	
350 N. Humphreys Blvd.	Memphis	TN	38120
Street or Route	City	State	Zip Code
Employee	901-227-4137	901-227-5004	
Association with Owner	Phone Number	Fax Number	

3. ***Owner of the Facility, Agency or Institution***

Baptist Memorial Rehabilitation Hospital, G.P.		901-476-2621
Name		Phone Number
5250 Virginia Way, Suite 240		Williamson
Street or Route		County
Brentwood	TN	32027
City	State	Zip Code

4. ***Type of Ownership of Control (Check One)***

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership	X	G.	
C. Limited Partnership		H. Joint Venture	
D. Corporation (For Profit)		I. Limited Liability Company	
E. Corporation (Not-for-Profit)		Other (Specify)	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***

CHC Management Services, LLC
Name

5250 Virginia Way, Suite 240 — Williamson
Street or Route — County

Brentwood — TN — 32027
City — State — Zip Code

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A. Ownership		D. Option to Lease	X
B. Option to Purchase		E. Other (Specify)	
C. Lease of ____ Years			

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A. Hospital		I. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		K. Recuperation Center	
D. Home Health Agency		L. Rehabilitation Facility	X
E. Hospice		M. Residential Hospice	
F. Mental Health Hospital		N. Non-Residential Methadone Facility	
G. Mental Health Residential Treatment Facility		O. Birthing Center	
H. Mental Retardation Institutional Habilitation Facility (ICF/MR)		P. Other Outpatient Facility (Specify)_____	
		Q. Other (Specify) _____	

8. ***Purpose of Review (Check) as appropriate--more than one response may apply)***

A. New Institution	X	G. Change in Bed Complement [*Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*]	
B. Replacement/Existing Facility			
C. Modification/Existing Facility			
D. Initiation of Health Care Service as defined in TCA § 68-11-1607(4) ()		H. Change of Location	X
E. Discontinuance of OB Services		I. Other (Specify)_____	
F. Acquisition of Equipment			

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

(Note: The beds below will be at the proposed new hospital, although the project involves a relocation of beds from an existing facility. Please refer to explanation below)

		Current Beds Licensed	Current Beds *CON	Staffed Beds	Beds Proposed	TOTAL Beds at Completion
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation *(Please see note below)*	0		0	49	49
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	0		0	49	49

*CON-Beds approved but not yet in service

Explanation Note** 49 IRF beds at Baptist Rehabilitation-Germantown will be delicensed at 2100 Exeter Road, Germantown, when the equivalent number of beds are opened and certified at the new proposed rehabilitation hospital. Therefore, this project will not add IRF beds to the community. It will improve existing capacities with a relocation of IRF beds.

10. **Medicare Provider Number** Rehab Facility will apply for new Number
Certification Type IRF

11. **Medicaid Provider Number** Rehab Facility will apply for new Number
Certification Type IRF

12. **If this is a new facility, will certification be sought for Medicare and/or Medicaid? Yes**

13. ***Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.*** **Will this project involve the treatment of TennCare participants?** Yes **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

TN Care MCOs: BCBST Blue Care, TN Care Select, Americhoice

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.

Response:
The Executive Summary is provided on the following pages.

Executive Summary.

The inpatient rehabilitation unit at Baptist Rehabilitation – Germantown serves patients after stays at Baptist Memorial Hospital– Memphis and Collierville and other hospitals in the region by providing a comprehensive array of rehabilitation services to treat many types of injuries and conditions, such as stroke, arthritis, spine and back disorders and injuries, fractures, amputations, and spinal cord and head injuries. Baptist Rehabilitation – Germantown operates 49 inpatient rehabilitation beds in 21 semiprivate rooms and only 7 private rooms. Semi private rooms were the standard when the hospital was opened in the early 90's and rehabilitative care has developed over the years.

A new facility is now needed to better align patient services with patient needs and expectations and to support utilization of the entire 49 bed complement of the inpatient rehabilitation facility (IRF). Space is needed to support patient flow and service management in contiguous therapy, dining, and exercise areas. Private rooms will accommodate specific patient needs and expectations for comfort and convenience. Private rooms will also eliminate problems in matching appropriate patients in semi-private rooms which hampers utilization. However, an addition at the existing rehabilitation location isn't feasible.

Constructing a modern inpatient rehabilitation facility (IRF) to serve the same community and relocating the 49 rehabilitation beds to it will provide better access and improve utilization without adding new rehabilitation beds. A comfortable care environment will support patients' efforts to return to normal function and promote staff cohesion, communication, productivity and satisfaction.

Upon completion of the proposed facility, Baptist Rehabilitation –Germantown ("BRG") will delicense its 49 inpatient rehabilitation beds. BRG will continue to provide outpatient rehabilitation services and to operate its existing 18- bed skilled nursing unit.

Proposed Services & Equipment

Baptist Memorial Health Care and Centerre Healthcare have formed a joint venture that proposes to establish and operate a brand new, state-of-the-art 49 bed (all private rooms) freestanding inpatient rehabilitation hospital approximately 2.5 miles away from the current facility. Although a new rehabilitation hospital will be built, bed capacity will be improved by making existing beds more functionally accessible rather than by adding new ones. If approved, Baptist Rehabilitation – Germantown will continue to provide inpatient rehabilitation services during the development of the new hospital, thus eliminating/limiting any gap in service.

The proposed new hospital will have the needed additional space, as well as added features and specialized equipment that allow for the expansion of services and enhancements to create more program specialization. For example,

- The entire specialty hospital is designed to meet the needs of persons with a disabling condition including all private, ADA compliant patient rooms and bathrooms (not all patient rooms in current facility are ADA compliant) with features that assist the person with a disability to become more independent.
- The Activity of Daily Living (ADL) space or room allows family members the ability to practice safe techniques such as bathing, transferring from bed to chair, etc. prior to taking the patient home. This reinforces family learning and helps with successful discharge to home.

- The mobility courtyard includes simulation of curbs, rough and smooth services, and various depths of steps. Practice on these skills allows persons to be mobile in the community.
- Larger therapeutic gym space allows patients to receive their therapeutic exercises and training in an environment where they are able to see other patients with disabilities making progress, thus serving as support to help each patient progress toward their goals
- The addition of private treatment rooms allow for a flexible environment, depending on patient needs. Large common areas allow for improved socialization skills when recovering from a disabling condition.
- A specialized Stroke/Neurological Unit (24-26 beds) to meet the needs of the approximately 3,000 MDC 1 (Diseases and Disorders of the Nervous System – See Exhibit B.1) patients being discharged by Baptist Memorial and other hospitals in a safe and "secure" environment. This specialized unit is self contained, including dedicated therapy and treatment space. It is difficult for an older facility with primarily semi-private rooms to modify the environment to apply such safety features and specialized treatments. The hospital would also offer specialized programming to serve the needs of Baptist Memorial's significant Brain Injury patient population.

Ownership Structure

The new hospital will be owned and operated by the partnership formed by an affiliate of Baptist Memorial Health Care and an affiliate of Centerre Healthcare. Baptist Memorial has a 55% ownership interest and Centerre Healthcare completes the additional 45% interest. A Board of Directors comprised of members from both parties will govern the operations of the new hospital and will ensure that Baptist Memorial Health Care Corporation's Ethical and Religious Directives (ERD's) and Charity Policies are followed. A third party developer or REIT will purchase/develop the land and building and lease it back to the joint venture. (See Joint Venture Ownership Structure – **Attachment** A-4

Service Area

The service area for the proposed hospital will continue to be primarily Shelby County where more than 70% of inpatients originate. Many patients at the current rehabilitation facility have been discharged from Baptist Memorial Hospital – Memphis or Baptist Memorial Hospital – Collierville to the Germantown Rehabilitation facility.

Need

Upon completion of the proposed facility, Baptist Rehabilitation-Germantown will delicense its 49 inpatient rehabilitation beds. Thus, the proposed project will not add beds to the service area but will provide an inpatient rehabilitation facility that has all ADA compliant, private rooms and state-of-the-art equipment and facilities. These improvements will allow more effective capacity (semi-private rooms limit capacity due to gender issues, disease control issues, etc.), establish a "Center of Excellence" for the greater Memphis area (See Exhibit B.4 - Centerre Clinical Indicators for Centerre's outstanding clinical outcomes) and better serve the community by creating specialized programs for stroke, neurological disorders and brain injury patients.

The increased capacity and specialized programming will strengthen the post-acute continuum and maintain highly acute patient populations. Enhancing the ability to care for medically complex patients will reduce the likelihood of readmissions and thus reduce the overall cost of care.

Existing Resources

There are 5 hospitals in Shelby County with certified inpatient rehabilitation beds (including Baptist Rehabilitation – Germantown) and the total number of beds in service is 218. Since this project does not add beds and serves the same area, this project will not impact the other facilities.

Project Cost, Funding, Financial Feasibility and Staffing

- Total Project Costs are estimated to be approximately $33,167,900 including lease costs in the total amount of $ 30,286,183 over the initial term of the lease.
- As demonstrated in the Projected Data Chart (Exhibit C: Economic Feasibility.4), the proposed new hospital will operate with a slight negative financial margin in Year 1. Start-up costs inherent in developing and operating the new hospital will contribute to the negative margin. Additionally, the new hospital will obtain a provider number and go through licensure and certification and will therefore ramp slowly over the first three months of operation. Beginning in Year 2, the proposed hospital will operate with a positive financial margin. The proposed hospital will have effectively the same charge structure as the current unit at Baptist Rehabilitation – Germantown.
- At maturity, it is anticipated that the new hospital will require approximately 130 total FTE's – clinical and non-clinical; nurses, therapists, and administrative staff (primarily recruited from existing Baptist Memorial locations). A CEO will be hired to manage the day-to-day operations of the hospital. The CEO will report to a Board of Managers, with equal representation from both Baptist Memorial and Centerre. The Board of Managers will work closely with a Community Advisory Committee. A Medical Director will be appointed to oversee and implement the clinical programming for the hospital. (See Exhibit B.5 for Hospital Organization Chart, with additional oversight roles).

Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.

A. Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project.

If the project involves none of the above, describe the development of the proposal.

Response:

See Exhibit B.II.a (Square Footage and Cost per Square Footage Chart) for detail regarding units/departments within the proposed new hospital. The completed hospital will include 49 ADA compliant, private patient bedrooms with private bathrooms. Additionally, the hospital will have a kitchen and cafeteria, ADL space, therapeutic gym space, mobility courtyard, and other staff support offices and spaces (nursing, therapy, administrative).

The hospital will be designed to accommodate specialized programs for stroke and neurological disorders. The project involves approximately 59,400 sq. ft. of new construction. As shown on the Square Footage and Cost per Square Footage Chart, the construction costs for the project are estimated at $15.4M (or $259.66/sq ft. (See Exhibit B.II.a)).

The building will be developed by a 3rd party developer or REIT. Construction cost per square foot for hospital projects approved by the HSDA for the years 2009-2011 are illustrated below. The cost per square foot for the proposed hospital is consistent with ranges of those projects, being below the median for new hospital construction:

Figure B.II.a

Hospital Construction Cost per Square Foot
Source: CON Approved Applications for Years 2009 through 2011

Subpopulations	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$273.69/sq ft	$324.00/sq ft	$301.74/sq ft

B. Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.

Response:

This application requests the establishment of a new inpatient rehabilitation hospital with 49 beds. However, since the existing facility will delicense 49 beds, the practical effect is relocation of 49 inpatient rehabilitation beds. As previously mentioned, relocation of the beds from the current location to the new hospital will allow for increased capacity and specialized programming with all ADA compliant private rooms, state-of-the-art equipment and facilities.

Square Footage and Cost Per Square Footage Chart

A. Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final	Proposed Final Square Footage			Proposed Final Cost/SF		
					Renovated	New	Total	Renovated	New	Total
ADL Suite						546	546		$ 259.66	$ 141,774
Administration						2,897	2,897		$ 259.66	$ 752,235
Dayroom						664	664		$ 259.66	$ 172,414
Dietary						3,528	3,528		$ 259.66	$ 916,080
Dining						1,093	1,093		$ 259.66	$ 283,808
Gym						5,359	5,359		$ 259.66	$ 1,391,518
Gym (Brain Injury)						689	689		$ 259.66	$ 178,906
Lab						75	75		$ 259.66	$ 19,475
Lobby						1,739	1,739		$ 259.66	$ 451,549
Patient Rooms						8,691	8,691		$ 259.66	$ 2,256,705
Patient Rooms (Brain Injury)						4,233	4,233		$ 259.66	$ 1,099,141
Patient Rooms (Stroke)						4,354	4,354		$ 259.66	$ 1,130,560
Pharmacy						348	348		$ 259.66	$ 90,362
Speciality Bathing						150	150		$ 259.66	$ 38,949
Storage						1,725	1,725		$ 259.66	$ 447,914
Support						6,314	6,314		$ 259.66	$ 1,639,493
B. Unit/Depart. GF Sub-Total						***42,405***	***42,405***		***$ 259.66***	***$ 11,010,882***
C. Mechanical/Electrical GSF						1,955	1,955		$ 259.66	$ 507,635
D. Circulation/Structure GSF						15,040	15,040		$ 259.66	$ 3,905,286
E. Total GSF					-	59,400	59,400	$ -	$ 259.66	$ 15,423,804

C. As the applicant, describe your need to provide the following health care services (if applicable to this application):

1. Adult Psychiatric Services
2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)
3. Birthing Center
4. Burn Units
5. Cardiac Catheterization Services
6. Child and Adolescent Psychiatric Services
7. Extracorporeal Lithotripsy
8. Home Health Services
9. Hospice Services
10. Residential Hospice
11. ICF/MR Services
12. Long-term Care Services
13. Magnetic Resonance Imaging (MRI)
14. Mental Health Residential Treatment
15. Neonatal Intensive Care Unit
16. Non-Residential Methadone Treatment Centers
17. Open Heart Surgery
18. Positron Emission Tomography
19. Radiation Therapy/Linear Accelerator
20. **Rehabilitation Services**
21. Swing Beds

Response:

This application is necessary to continue providing an essential level of patient care in the most effective manner possible. The service configuration for the inpatient rehabilitation unit that has been in place since the early 90's relies heavily on semi-private rooms at Baptist Rehabilitation -Germantown. Improvements cannot feasibly be accomplished without adding space. The proposed new inpatient rehabilitation facility will be licensed as a freestanding Rehabilitation Hospital. The inpatient rehabilitation beds at the rehabilitation unit will cease and beds at the hospital will begin without adding beds in the community. It is an improvement in the functionality of existing resources.

The system that identifies patients whose needs are appropriately served by IRFs has changed over the years through adjustments in the Medicare payment system. Inpatient rehabilitation is particularly effective for patient populations with a large number of stroke/neurological disorders, as well as musculoskeletal and medically complex disabling conditions, a majority of which fall within the nervous system disorders or Major Diagnostic Category 1 (MDC 1). Baptist Memorial Hospital in Memphis and Collierville is responsible for a large population of patients with these diagnoses (approximately 3,000 total MDC 1 discharges in Shelby County). By developing the 60% Rule and CMS 13 criteria (See Exhibit C: Need.6); CMS has specifically encouraged inpatient rehabilitation providers to assume responsibility for these types of patients. Establishing a state-of-the-art freestanding rehabilitation hospital, with specialized clinical services focused on such conditions ensures that the capability of providing high quality care will be available to these patients.

Baptist's commitment to providing high quality services is demonstrated by the CARF accreditation for Stroke and Brain Injuries. CARF is an independent, nonprofit organization that focuses on advancing the quality of services and evaluating healthcare providers' commitment to continually improving services and serving the community. The new hospital expects to achieve CARF accreditation for these specialties as part of its mission to enhance the specialized programs that Baptist provides to the Memphis and Shelby County community. In this way, the joint venture will establish a "Center of Excellence" that is not currently available to the community.

Sufficient capacity and adequate facilities to continue providing effective care in an efficient and effective manner involves attention to the needs of professionals who provide the care. The proposed new hospital will add no new beds to the service area but will provide the community with an inpatient rehabilitation facility that has all ADA compliant, private rooms (49) and state-of-the-art equipment in a patient oriented facility equipped to continue improvements in specialized programs such as the stroke/neurological and brain injury patient populations.

The over 65 population cohort for Shelby County is growing at a rate that exceeds population growth for the state of Tennessee overall (see Figure C: Need.4.1). For rehabilitation patients currently served, more than 60% of the patient mix for the current hospital and the proposed hospital are Medicare patients. It is important that the adequate capacity be available to appropriately meet the needs of these patients.

D. Describe the need to change location or replace an existing facility.

Response:

While technically not a relocation, the project, practically speaking will relocate a service so that resources can be more effectively utilized by the community. The current inpatient rehabilitation beds are located in mostly semi-private rooms in a facility that cannot feasibly expand. The proposed new state-of-the-art facility will increase the inpatient rehabilitation capacity and allow improvements in service that will increase patient access and encourage participative effort in specialized therapies, and improve satisfaction.

Renovation of the current facility to provide all ADA compliant, private rooms is not feasible.

E. Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $2.0 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:

Response:

N/A Not applicable

1. For fixed-site major medical equipment (not replacing existing equipment):
   a. Describe the new equipment, including:
      1. Total cost ;(As defined by Agency Rule).
      2. Expected useful life;
      3. List of clinical applications to be provided; and
      4. Documentation of FDA approval
   b. Provide current and proposed schedules of operations
2. For mobile major medical equipment
   a. List all sites that will be served;
   b. Provide current and/or proposed schedule of operations;
   c. Provide the lease or contract cost.
   d. Provide the fair market value of the equipment; and
   e. List the owner for the equipment.
3. Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.

III. (A) Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which **must include**:

1. Size of site (***in acres***);
2. Location of structure on the site; and
3. Location of the proposed construction.
4. Names of streets, roads or highway that cross or border the site.

Response:

The size of site is 6.1 acres. Please see Exhibit B.III.A for detailed plot plan.

Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.

(B) 1 Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response:

Public transportation is easily accessible on Germantown Parkway and Wolf River Boulevard (shown in the plot plan). The site is located on an intersection that allows for direct access (one street, within five miles) to I40, I240, and Hwy 385.

IV. Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.

Response:

Please refer to Exhibit B.IV for detailed floor plan drawings and square footage by department.

NOTE: ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

V. For a Home Health Agency or Hospice, identify:

1. Existing service area by County;
2. Proposed service area by County;
3. A parent or primary service provider;
4. Existing branches; and
5. Proposed branches.

Response:

Not applicable

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

NEED

1. Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.

   Response

   The proposed hospital will support all Five Principles established by the state of Tennessee to promote the health of Tennesseans and to implement the State Health Plan:

The Framework for Tennessee's Comprehensive State Health Plan

Five Principles for Achieving Better Health

The following Five Principles for Achieving Better Health serve as the basic framework for the State Health Plan.

(1) Healthy Lives

The purpose of the State Health Plan is to improve the health of Tennesseans.

Every person's health is the result of the interaction of individual behaviors, society, the environment, economic factors, and or genetic endowment. The State Health Plan serves to facilitate the collaboration of organizations and their ideas to help address health at these many levels.

Response:

The proposed new hospital will improve the coordination and scope of services offered to patients in need of specialized medical rehabilitation through the designated 24-26 bed stroke/neurological unit. The design of the new hospital with its' designated specialty units and specialized services will offer a more comprehensive medical rehabilitation service for those patients.

(2) **Access to Care**

Every citizen should have reasonable access to health care.

Many elements impact one's access to health care, including existing health status, employment, income, geography, and culture. The State Health Plan can provide standards for reasonable access, offer policy direction to improve access, and serve a coordinating role to expand health care access.

Response:

The proposed new rehabilitation hospital will improve access to specialized medical rehabilitation services in the community and surrounding region. The adoption of Baptist Memorial's ERDs and charity policies will ensure that the Baptist Memorial's mission continues to guide admission policies.

3. **Economic Efficiencies**

The state's health care resources should be developed to address the needs of Tennesseans while encouraging competitive markets, economic efficiencies and the continued development of the state's health care system. The State Health Plan should work to identify opportunities to improve the efficiency of the state's health care system and to encourage innovation and competition.

Response:

By reassigning existing beds to the new environment specially designed for the needs of those with disabling conditions, there is an improvement in access to and improved efficiency for specialized services as well as enhanced medical rehabilitation.

4. **Quality of Care**

Every citizen should have confidence that the quality of health care is continually monitored and standards are adhered to by health care providers. Health care providers are held to certain professional standards by the state's licensure system. Many health care stakeholders are working to improve their quality of care through adoption of best practices and data-driven evaluation.

Response:

The new technologies and electronic health record tools will ensure that patient information is appropriately accessible to providers and that patient treatments can be monitored. The environment of the new specialty rehabilitation hospital, with features that allow the person with a disability to achieve an improved level of independence upon discharge, minimizes the risk of readmission to acute care

5. **Health Care Workforce**

The state should support the development, recruitment, and retention of a sufficient and quality health care workforce. The state should consider developing a comprehensive approach to ensure the existence of a sufficient, qualified health care workforce, taking into account issues regarding the number of providers at all levels and in all specialty and focus areas, the number of professionals in teaching positions, the capacity of medical, nursing, allied health and other educational institutions, state and federal laws and regulations impacting capacity programs, and funding.

Response:

This project consolidates resources including healthcare professionals who are already engaged in providing the services. By dedicating space and equipment for specialized services such as Traumatic Brain Injury, Spinal Cord Injury, Stroke and other disabling conditions, the new hospital will play a significant role in recruiting more specialized healthcare professionals, including

Physicians Specializing in Physical Medicine and Rehabilitation, Rehabilitation Nursing, and Physical, Occupational and Speech language Pathologists.

a. Please provide a response to each criterion and standard in Certificate of Need Categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.

Response:

Although this application does not propose additional bed capacity or new services in the community, responses to the criteria for Comprehensive Inpatient Rehabilitation Services and Construction, Renovation, Expansion, and Replacement of Health Care Institutions are provided on the following pages.

COMPREHENSIVE INPATIENT REHABILITATION SERVICES

1. The need for comprehensive inpatient rehabilitation beds shall be determined by applying the guideline of ten beds per 100,000 population in the service area of the proposal.

   Response

   The primary service area of the proposal is Shelby County. Statistics from the Department of Health website indicate the population of Shelby County is 949,665 in 2012 and will be 976,726 in 2016. At 10 beds per 100,000, the need is 95 (rounded) beds in 2012 and will be 98 (rounded) in 2016.

2. The need shall be based upon the current year's population and projected four years forward.

   Response

   As described above, at 10 beds per 100,000, the need is 95 (rounded) beds in 2012 and will be 98 (rounded) in 2016.

Although the need is based on population, other characteristics of patient need include the age cohorts of the population and the type of rehabilitation care needed. CMS has identified 13 types of care that are appropriate for inpatient rehabilitation facilities. As discussed in other sections of the application, Centerre Healthcare has applied it's methodology to patients who are discharged from BMH-Memphis and BMH-Collierville. Patients from those two facilities alone demonstrate sufficient support for the proposed 49 bed facility. The result of the analysis is displayed in the following table:

Rehabilitation Bed Need Analysis
Baptist Memorial Hospital - Memphis & Collierville

Source: Hospital Data - Baptist Memorial Date Period: FY 2010				All Payor Cases		
Diagnostic Category	Total of All Payor Cases	Average Length of Stay	Percent Requiring Rehab	Rehab Aprop. Cases	Projected Rehab Patient Days	Projected Rehab ADC
Stroke	1,242	17.6	40%	497	8,744	24.0
Traumatic Brain Injury	271	17.6	30%	81	1,431	3.9
Non Traumatic Brain Injury	241	15.6	30%	72	1,128	3.1
Traumatic Spinal Cord Injury	-	27.2	50%	-	-	-
Non Traumatic Spinal Cord Injury	18	18.0	25%	5	81	0.2
Neurological	812	14.3	40%	325	4,645	12.7
Fracture of lower extremity	312	13.8	25%	78	1,076	2.9
Replacement of lower extremity joint	709	10.8	5%	35	383	1.0
Other Orthopedic	379	12.7	15%	57	722	2.0
Amputation, lower extremity	76	13.5	15%	11	154	0.4
Amputation, non-lower extremity	4	13.1	10%	0	5	0.0
Osteoarthritis	-	11.3	10%	-	-	-
Rheumatoid	-	10.6	10%	-	-	-
Cardiac	-	11.9	10%	-	-	-
Pulmonary	-	12.9	1%	-	-	-
Pain Syndrome	-	10.5	1%	-	-	-
MMT without Brain or Spinal Cord Injury	52	13.8	50%	26	359	1.0
MMT with Brain or Spinal Cord Injury	1	21.6	50%	1	11	0.0
Guillan Barre	-	14.0	80%	-	-	-
Burns	6	16.5	25%	2	25	0.1
	4,123			1,190	18,763	51.4

ALL PAYOR	
Estimated All Payor ADC	51.4
Selected DRGs	
Adjusted 35% for all other DRG's	79.1
Add additional 35% for non-compliant cases	

Please Note: ALOS has been updated as of 4/25/11 by the Nation Adjusted Mean LOS from UDS.

3. Applicants shall use a geographic service area appropriate to inpatient rehabilitation services .
   Response:
   As previously presented, based on patient origin, more than 70% of the current patients at Baptist Memorial-Germantown originate from Shelby County. More than 77% originate from Shelby, Fayette and Tipton Counties.

4. Inpatient rehabilitation units in acute care hospitals shall have a minimum size of 8 beds.
   N/A Not Applicable

5. Freestanding rehabilitation hospitals shall have a minimum size of 50 beds.
   Response
   For conservative planning and implementation, this proposal maintains the same number of beds at the new hospital as the same number of beds that are at Baptist Rehabilitation- Germantown at 49 beds.
   An additional bed can be accommodated at the new facility if the Agency determines that it is needed.

6. Additional inpatient rehabilitation beds, units, or freestanding hospitals should not be approved by the HFC unless all existing units or facilities are utilized at the following levels:

20-30 bed unit	~ 75%
31-50 bed unit/facility	~ 80%
51 bed plus unit/facility	~ 85%

   Response
   This application does not propose adding new inpatient rehabilitation beds to the community. As discussed in response to items 1 and 2 above, discharges from hospitals operated by Baptist Memorial Health Care are sufficient to utilize the beds proposed for the hospital alone.

7. The applicant must document the availability of adequate professional staff, as per licensing requirements, to deliver all designated services in the proposal. It is preferred that the medical director of a rehabilitation hospital be a board certified physiatrist.
   Response
   Since the proposed hospital will contain relocated beds that are currently in use, and one of the partners has access to resources for staffing throughout the wider region, the applicant has a source for staffing the proposed project.
   Positions are shown on the following page.

Paid FTE's by Category	Year 1	Year 2
Nursing	61	63
Therapy	24	24
Admin/Non-Clinical	46	50
Total	131	137

TITLE	End of Year 1	End of Year 2
	FTE	FTE
Nursing		
RN's	19.8	20.3
LPN's	12.9	13.2
Aides	17.1	17.6
Charge Nurse	4.2	4.2
Total Nursing FTE's	54.0	55.3
Total Paid Nursing FTE's	61.5	62.9
Therapy		
Physical Therapists	6.3	6.3
PTA	3.0	3.0
Occupational Therapists	5.5	6.0
COTA	3.0	3.0
Techs	-	-
SLPs	3.0	3.0
Total Therapy FTE's	20.8	21.3
Total Paid Therapy FTE's	23.6	24.2

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.
N/A Not Applicable

2. For relocation or replacement of an existing licensed health care institution:
N/A Not Applicable

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

3. For renovation or expansions of an existing licensed health care institution:
N/A Not Applicable.

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

b. Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c)

Response:

This application represents a relocation of services rather than a change of site for a health care institution. However, responses to the General Criterion and Standards (4)(a)-(c) are addressed as follows:

(a)*Need.* The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change the proposed new site.

Response
The proposed site for the new Rehabilitation is less than 2.5 miles from the current service location in Germantown. The Inpatient Rehabilitation Facility will be no less conveniently accessible to the population of the service area. In addition to being an established service in the community, the description provided in Section C:Need, Question 6 of this application demonstrates continuing need for the service in an improved setting. The new site will continue to provide convenient access for the patients served.

(b)*Economic Factors.* The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

Response
See the response to item (a) above. As stated above, the charge schedule of the current hospital will be the same charge schedule as the new hospital and the Board of Managers will be governed by the ERD's. Additionally, the benefits of having specialized services in a new state-of-the-art-facility will enable Baptist Memorial to reduce the cost of service.

(c)*Contribution to the orderly development of health facilities and/or services.* The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such changes delays are outweighed by the benefits that will be gained from the change of site by the population to be served.

Response
The current hospital will operate at least until the new hospital is opened, thus eliminating/limiting any gap in provision of the service. Additionally, the new facility is in close proximity of the existing facility, therefore established referral patterns will be maintained.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any.

Response:

The Baptist Memorial Health Care system continuously reviews health needs throughout the region and is committed to providing Mid-South patients, families, and physicians with the assurance and confidence that comes from excellent, compassionate, advanced care in the most effective manner possible.

The proposed Baptist Rehabilitation Hospital will improve the delivery system using existing capacities in new surroundings. The strength from collective services for treating inpatient rehabilitation patients will be more easily accessible to the people who need it most. The Baptist Memorial system has approximately 3,000 MDC 1 (Diseases and Disorders of the Nervous System) patients. As described in detail later in this document (Section C: Need, Question 6), CMS has encouraged the inpatient rehabilitation industry to focus on these types of diagnoses (Stroke, Neurological Disorders, Brain Injury, etc.) as the types of patients most likely to require and benefit from inpatient rehabilitation.

Centerre's model identifies the treatment needs for these patients since the high volume being treated by Baptist Memorial Health Care in the Memphis area is a significant factor in the need for the proposed hospital. Consequently, it is proposed that the new hospital will have all ADA compliant, private rooms with a 24-26 bed specialized stroke/neurological unit and specialized programming for Brain Injuries.

This project continues to be consistent with the long range development plan of Baptist to accommodate the health needs of the community it serves while maintaining patient, physician and staff satisfaction with high quality and safety.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. **Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).**

Response:

A map is provided as Exhibit C: Need.3 (Service Area Maps). The Service Area is reasonable since it represents the origin of patients. The primary service area is Shelby County in Tennessee. An expanded secondary area will include all of the West Tennessee counties which will be served by the proposed new hospital. More than 75% of inpatient admissions reside in the primary Shelby County and secondary Fayette and Tipton County area.

4. A. Describe the demographics of the population to be served by this proposal.

Response:

The estimated population for this year and the next 4 years is provided for primary service area of Shelby County and the secondary areas of Tipton and Fayette counties in the following Chart.

Tennessee Population by County
Source: TN Department of Health

COUNTY	2012	2013	2014	2015	2016
Shelby	949,665	956,126	963,097	970,591	976,726
Fayette	39,245	39,818	40,435	41,105	41,453
Tipton	62,952	63,857	64,813	65,839	66,587
TOTAL	1,051,862	1,059,801	1,068,345	1,077,535	1,084,766

	2010			2018		
County	Total Population	under 60	over 60	2018	under 60	over 60
Shelby	918,680	771,060	147,620	938,404	749,862	188,542
Tipton	60,340	50,550	9,790	66,953	54,078	12,875
Fayette	41,553	34,383	9,535	51,076	41,973	9,103

Population	Growth 2010 - 2018		
County	Growth	Growth under 60	Growth over 60
Shelby	2.1%	-2.7%	27.7%
Tipton	11.0%	7.0%	31.5%
Fayette	22.9%	22.1%	-4.5%

According to the U.S. Census Bureau, the population estimate of Shelby County in 2011 was 935,088. It is Tennessee's largest county in both size and population. The state projects the total population in Shelby County will grow by 7.55% by the year 2020. The Tennessee Department of Health estimates that Shelby County will see an increase in population for those 65 and older (population most likely to require inpatient rehabilitation) by 35.6% by 2020 (compared to 26.3% for the state of Tennessee). The level of poverty in Shelby County exceeded the Tennessee average by 3.2% while the median household income from 2006-2010 was $44,705 (Tennessee average is $43,314).

Primary Service Area Demographic Data

Demographic/ Geographic Area	Shelby County	State of TN Total
Total Population - 2011 (est)	935,088	6,403,353
Total Population - 2020 (est)	1,005,678	6,785,100
Total Population Change	7.55%	5.96%
Age 65 & Over - 2011	97,249	877,259
Age 65 & Over - 2020 (est)	131,831	1,107,943
Age 65 & Over Population Change	***35.56%***	***26.30%***
Median Household Income (2006 - 2010)	$ 44,705	$ 43,314
Persons below poverty level % (2006 - 2010)	19.7%	16.5%

Sources: TDH Population projections, Feb. 2008; U.S. Census QuickFacts

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

The proposed new freestanding inpatient rehabilitation hospital will provide treatment services to the residents without regard to race, ethnic origin, ability to pay, religion, sex, or disability and will accept both Medicare and TennCare patients. As previously mentioned, a large majority of its services will be provided for the 65 and older community, which is growing faster in Shelby County than in Tennessee as a whole. In addition, the rehabilitation hospital will adhere to Baptist Memorial's ERD's and charity policy.

5. Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.

Response

Figure C: Need.5 on the following page shows the utilization that is reported on their Joint Annual Reports (JAR) from 2009 through 2011.

While all four providers in the service area averaged 68.9% in CY 2011, the two HealthSouth averaged 73.9% occupied (93.5% for HealthSouth North Memphis with 40 beds and 66.9% for HealthSouth Memphis with 80 beds). The applicant again points out that a new-state-of-the-art freestanding rehabilitation hospital with specialized programs and units as well as all private rooms is what the Memphis market needs for the projected aging population (see Figures C:Need.4.1 – C: Need.4.3 on the previous page). Additionally, the applicant is not requesting additional beds, but only to relocate the existing beds to a more efficient/appropriate setting.

Figure C: Need.5

Utilization of Acute Inpatient Rehabilitation Beds

Primary Service Area of Baptist Rehabilitation - Germantown

Joint Annual Report (JAR) Information: 2009 - 2011

	2009				
Inpatient Rehabilitation Provider	**Beds**	**No. of Discharges**	**Days**	**ADC**	**Occ**
HealthSouth Rehab of Memphis	80	1,541	20,052	54.9	68.7%
HealthSouth Rehab of N. Memphis	40	1,010	12,307	33.7	84.3%
Saint Francis Hospital	29	270	4,526	12.4	42.8%
Regional MC at Memphis	20	362	7,238	19.8	99.2%
Primary Service Area Totals	**169**	**3,183**	**44,123**	**120.9**	**71.5%**

	2010				
Inpatient Rehabilitation Provider	**Beds**	**No. of Discharges**	**Days**	**ADC**	**Occ**
HealthSouth Rehab of Memphis	80	1,511	19,879	54.5	68.1%
HealthSouth Rehab of N. Memphis	40	1,049	13,116	35.9	89.8%
Saint Francis Hospital	29	146	2,245	6.2	21.2%
Regional MC at Memphis	20	380	7,191	19.7	98.5%
Primary Service Area Totals	**169**	**3,086**	**42,431**	**116.2**	**68.8%**

	2011				
Inpatient Rehabilitation Provider	**Beds**	**No. of Discharges**	**Days**	**ADC**	**Occ**
HealthSouth Rehab of Memphis	80	1,582	19,529	53.5	66.9%
HealthSouth Rehab of N. Memphis	40	1,073	13,657	37.4	93.5%
Saint Francis Hospital	29	144	2,296	6.3	21.7%
Regional MC at Memphis	20	327	6,990	19.2	95.8%
Primary Service Area Totals	**169**	**3,126**	**42,472**	**116.4**	**68.9%**

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology **must include** detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

Figure C: Need.6.1 on the next page outlines BRG's utilization for the past 3 years. Even though the Baptist system easily has the rehab bed need to fill up a 49 bed freestanding rehabilitation hospital, their average daily census (ADC) has dropped each year because of semi-private rooms and limitations to most effectively providing specialized programming in the current setting.

Figure C: Need.6.1

Utilization of Acute Inpatient Rehabilitation Beds

Baptist Rehabilitation - Germantown

Inpatient Rehabilitation Provider	Year	Beds	No. of Discharges	Days	ADC	Occ
Baptist Rehabilitation - Germantown	2009	68	988	13,082	35.8	52.7%
Baptist Rehabilitation - Germantown	2010	68	803	10,290	28.2	41.5%
Baptist Rehabilitation - Germantown	2011	49	626	8,819	24.2	49.3%
Baptist - Germantown (3 Year)	**NA**	**.85**	**2,417**	**32,191**	**88.2**	**47.7%**

Source: TN Dept of Health Joint Annual Report (JAR) - http://health.state.tn.us/PublicJARS/Default.aspx

Note: 2009 and 2010 stats are from pg. 13. 2011 stats are from pg. 24.

Utilization Projections:

According to CMS, "The 60 percent rule, formerly known as the 75 percent rule, is a criterion used to define inpatient rehabilitation facilities in order for them to receive payment as an IRF. The rule requires that at least 60 percent of cases an IRF admits have one or more selected conditions. The 13 qualifying medical conditions used to classify a facility as an IRF are:"

- stroke
- spinal cord injury
- congenital deformity
- amputation
- major multiple trauma
- hip fracture
- brain injury
- neurological disorders
- burns
- 3 arthritis conditions for which appropriate, aggressive, and sustaine outpatient therapy has failed, and
- joint replacement for both knees or hips when the surgery immediatel precedes admission, when the BMI >= 50, or age 85+

Please see Exhibit C: Need.6 – CMS 60% Rule for further explanation.

The state of Tennessee's calculation for need of inpatient rehabilitation beds is determined by applying the guideline of ten beds per 100,000 of population in the service area. The population of Shelby County in 2011 was 935,088 (See Figure C: Need.4.1). At 10 beds per 100,000 persons, this methodology would identify a need of 94 beds. However, the calculations ignore the status of Memphis as a medical center serving a multi-state region.

Centerre's hospital specific MS-DRG methodology is more precise because it captures the actual volume of certain diagnoses that utilize inpatient rehabilitation facilities (IRF), such as Stroke, Brain Injury, Fracture Hip, etc. and applies a percent to IRF for each of the selected MS-DRGs. Given Baptist Memorial's significant number of cases that meet the 60% rule, this methodology most accurately reflects need. Additionally, the methodology applies greater weight to stroke, trauma, and neurological impairment categories of patients in need of specialized programs.

Below, Figure C: Need.6.2 shows the need projected for Baptist Memorial. The model uses a percentage of each Rehabilitation Impairment Category (RIC) based on Centerre Healthcare's experience with six operating rehabilitation hospitals by assigning definitively compliant MS-DRGs to a RIC. Next, an Average Length of Stay (ALOS) was assigned based on the Uniform Data System (UDS is a collection of over 830 inpatient rehabilitation hospitals and units' clinical data). The UDS nation adjusted mean was used for the ALOS to calculate the number of days.

Step 1: The applicant used Baptist Memphis and Collierville's all payer data from 2010. There were 30,086 total discharges, 4,123 met the 13 qualifying medical conditions for the 60% rule.
Step 2: The next step is to determine how many of these 4,123 compliant discharges would be appropriate for rehab (see calculations on Figure C: Need.6.2).
Step 3: Calculate the number of patient days (take the ALOS for each RIC and multiply by the number of cases – see calculations on Figure C: Need.6.2).
Step 4: Calculate the Average Daily Census (ADC) by dividing the number of patient days by 365 (see calculations on Figure C: Need:6.2). This gives us a compliant ADC of 51.4.
Step 5: Calculate the Average Daily Census for the non-compliant cases. This model assumes that only 35% would be non-compliant cases (even though CMS allows 40% of cases to be non-compliant). This gives us a non-compliant ADC of 27.7 and a total rehab ADC of 79.1.

Figure C: Need.6.2

Rehabilitation Bed Need Analysis Baptist Memorial Hospital - Memphis & Collierville						
Source: Hospital Data - Baptist Memorial Date Period: FY 2010				All Payor Cases		
Diagnostic Category	Total of All Payor Cases	Average Length of Stay	Percent Requiring Rehab	Rehab Aprop. Cases	Projected Rehab Patient Days	Projected Rehab ADC
Stroke	1,242	17.6	40%	497	8,744	24.0
Traumatic Brain Injury	271	17.6	30%	81	1,431	3.9
Non Traumatic Brain Injury	241	15.6	30%	72	1,128	3.1
Traumatic Spinal Cord Injury	-	27.2	50%	-	-	-
Non Traumatic Spinal Cord Injury	18	18.0	25%	5	81	0.2
Neurological	812	14.3	40%	325	4,645	12.7
Fracture of lower extremity	312	13.8	25%	78	1,076	2.9
Replacement of lower extremity joint	709	10.8	5%	35	383	1.0
Other Orthopedic	379	12.7	15%	57	722	2.0
Amputation, lower extremity	76	13.5	15%	11	154	0.4
Amputation, non-lower extremity	4	13.1	10%	0	5	0.0
Osteoarthritis	-	11.3	10%	-	-	-
Rheumatoid	-	10.6	10%	-	-	-
Cardiac	-	11.9	10%	-	-	-
Pulmonary	-	12.9	1%	-	-	-
Pain Syndrome	-	10.5	1%	-	-	-
MMT without Brain or Spinal Cord Injury	52	13.8	50%	26	359	1.0
MMT with Brain or Spinal Cord Injury	1	21.6	50%	1	11	0.0
Guillan Barre	-	14.0	80%	-	-	-
Burns	6	16.5	25%	2	25	0.1
	4,123			1,190	18,763	51.4

Please Note: ALOS has been updated as of 4/25/11 by the Nation Adjusted Mean LOS from UDS.

ALL PAYOR	
Estimated All Payor ADC	51.4
Selected DRGs	
Adjusted 35% for all other DRG's	79.1
Add additional 35% for non-compliant cases	

Based on the large number of discharges that are rehab appropriate, specifically those within the stroke/neurological categories, the applicant is confident in the projected utilization for the proposed rehabilitation hospital with all private rooms (see Figure C: Need.6.3 below). In fact, the projections are extremely conservative given the high number of discharges in the Baptist Memorial System and the fact that discharges from other acute care hospitals are not taken into account. The first year's census is broken into 4 quarters. This is to demonstrate the new hospital ramping up the census in year one after it receives Medicare certification (typically between 45-75 days after opening).

Figure C: Need.6.3

Utilization of Acute Inpatient Rehabilitation Beds
Baptist Rehabilitation - Germantown
Projected Volume with New Hospital

Quarter / Year	Beds	No. of Discharges	Days	ADC	Occ
Q3 - 2014	49	43	605	6.6	13.4%
Q4 - 2014	49	234	3,309	36.0	73.4%
Q1 - 2015	49	250	3,541	39.3	80.3%
Q2 - 2015	49	257	3,640	40.0	81.6%
Year 1 Totals	**49**	**784**	**11,095**	**30.4**	**62.0%**
Year 2 Totals	**49**	**1,061**	**15,006**	**41.0**	**83.7%**

The applicant would like to reiterate that the low projection of discharges in the first quarter of operations (Q3 – 2014) is due to the fact that the new hospital will undergo Medicare certification in that quarter. Additionally, the new hospital will achieve higher occupancy levels than the current rehabilitation hospital due to private rooms and a specialized programming.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

    - All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)

Response
The Chart has been completed on the following page. The CON filing fee has been calculated from Line D to be $45,000.

- The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

Response
The Chart has been completed on the following page. Lease values were used because the total lease cost of building and land over the initial term was greater than the estimated construction cost. The actual initial cash requirement is much less than the cost indicated by the chart. A third party developer will purchase/develop the land and building and lease it back to the joint venture. A letter indicating that arrangement is provided.

- The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

Response
The moveable equipment cost is $2,303,000. There are no major fixed equipment items included in the project.

- For projects that include new construction, modification, and/or renovation; **documentation must be** provided from a contractor and/or architect that support the estimated construction costs.

Response
The Chart has been completed on the following page with building costs included in the lease expense. Documentation from the firm of ESa is provided as **Attachment Section C Economic Feasibility 1.**

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:	
	1. Architectural and Engineering Fees	$ -
	2. Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$ 49,500
	3. Acquisition of Site	$ -
	4. Preparation of Site	$ -
	5. Construction Costs	$ -
	6. Contingency Fund	$ 484,217
	7. Fixed Equipment (not in included in Construction Contract)	$ 2,303,000
	8. Moveable Equipment (List all equipment over $50,000)	$ -
	9. Other (Specify) _____	$ -
B.	Acquisition by gift, donation, or lease:	
	1. Facility (inclusive of building and land)*	$ 30,286,183
	2. Building only	$ -
	3. Land only	$ -
	4. Equipment (Specify) _____	$ -
	5. Other (Specify) _____	$ -
C.	Financing Costs and Fees:	
	1. Interim Financing	$ -
	2. Underwriting Costs	$ -
	3. Reserve for One Year's Debt Service	$ -
	4. Other (Specify) _____	$ -
D.	Estimated Project Cost (A + B + C)	$ 33,122,900
E.	CON Filing Fee	$ 45,000
F.	Total Estimated Project Cost (D + E)	
	TOTAL	$ 33,167,900

* Lease costs over initial term of lease

2. Identify the funding sources for this project.

   Please check the applicable item(s) below and briefly summarize how the project will be financed. ***(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***

__ A. Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

__ B. Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

__ C. General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.

__ D. Grants--Notification of intent form for grant application or notice of grant award; or

_X_ E. Cash Reserves--Appropriate documentation from Chief Financial Officer.
Response:
The operations (working capital and equipment) will be funded by Centerre Healthcare's capital contribution to the joint venture. See Exhibit C: Economic Feasibility.2(E).

_X_ F. Other—Identify and document funding from all other sources.
Response:
As described in other responses, the land and building will be purchased by a third party developer/REIT and leased back to the joint venture. Documentation is provided from Duke Realty. Please See Exhibit C; Economic Feasibility 2 (F)

3. Discuss and document the reasonableness of the proposed project costs. If applicable, compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.

Response

Total cost of Construction and Site Preparation only is estimated at $15.4M (See Exhibit B.II.a - Square Footage and Cost per Square Footage Chart).

Construction cost per square foot for hospital projects approved by the HSDA for the years 2009-2011 are illustrated below. The cost per square foot for the proposed hospital is consistent with ranges of those projects, being below the median for new hospital construction:

Figure C: Economic Feasiblity.3

Hospital Construction Cost per Square Foot
Source: CON Approved Applications for Years 2009 through 2011

Subpopulations	Renovated Construction	New Construction	Total Construction
1st Quartile	$125.84/sq ft	$235.86/sq ft	$167.99/sq ft
Median	$177.60/sq ft	$274.63/sq ft	$249.32/sq ft
3rd Quartile	$273.69/sq ft	$324.00/sq ft	$301.74/sq ft

4. Complete Historical and Projected Data Charts on the following two pages--***Do not modify the Charts provided or submit Chart substitutions!*** Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the ***Proposal Only*** (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).

Response

The Historical Data Chart has been completed for the last three available fiscal years (2009 - 2011) for operations at Baptist Rehabilitation-Germantown.

The Projected Data Chart has been completed for the first 2 full years following project completion.

5. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge.

Response

Average Charge per discharge in Year 1 = $40,062
Average Deduction per discharge in Year 1 = $23,098
Average Net per discharge in Year 1 = $16,964

Average: Gross Charges, Deductions, Net Charges

	Year 1	Year 2
Inpatient Gross Revenue	$ 31,440,690	$ 43,374,038
Inpatient Deductions from Revenue	$ 18,290,235	$ 24,975,278
Inpatient Net Revenue	$ 13,217,021	$ 18,491,892
Discharges	785	1,061
Average Gross Charge per Discharge	$ 40,062	$ 40,863
Average Deduction per Discharge	$ 23,306	$ 23,530
Average Net Revenue per Discharge	$ 16,841	$ 17,422
Patient Days	11,095	15,006
Average Gross Charge per Patient Day	$ 2,834	$ 2,890
Average Deduction per Patient Day	$ 1,649	$ 1,664
Average Net Revenue per Patient Day	$ 1,191	$ 1,232

SUPPLEMENTAL- # 1
December 27, 2012
2:41pm

HISTORICAL DATA CHART

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in OCT (Month)

	Year 2009	Year 2010	Year 2011
A. Utilization Date (Discharges / Days)	626 / 8819	1043 / 12,693	803 / 10,290
B. Revenue from Services to Patients			
1. Inpatient Services	$ 30,408,795	$ 27,084,006	$ 27,202,752
2. Outpatient Services			
3. Emergency Serivces			
4. Other Operating Revenue (specify) cafeteria, gift shop, etc.	$ 1,697,812	$ 1,621,424	$ 1,412,266
Gross Operating Revenue	$ 32,106,607	$ 28,705,430	$ 28,615,018
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	$ 21,944,490	$ 13,993,170	$ 13,138,840
2. Provision for Charity Care	$ 383,028	$ 536,335	$ 210,898
3. Provision for Bad Debt	$ 462,000	$ 1,062,400	$ 574,975
Total Deductions	$ 22,789,518	$ 15,591,905	$ 13,924,713
NET OPERATING REVENUE	$ 9,317,089	$ 13,113,525	$ 14,690,305
D. Operating Expenses			
1. Salaries and Wages	$ 9,393,457	$ 8,535,739	$ 8,120,069
2. Physician's Salaries and Wages			
3. Supplies	$ 867,701	$ 622,947	$ 717,326
4. Taxes			
5. Depreciation	$ 990,938	$ 1,043,043	$ 1,001,799
6. Rent			
7. Interest, other than Capital	$ 25,433	$ 27,727	$ 25,351
8. Management Fees:			
a. Fees to Affilitates	$ 1,248,050	$ 1,360,921	$ 1,443,235
b. Fees to Non-Affilitates			
9. Other Expenses (Specify on separate page)	$ 1,550,619	$ 1,212,578	$ 1,294,941
Total Operating Expenses	$ 14,076,198	$ 12,802,955	$ 12,602,721
E. Other Revenue (Expenses) - Net (Specify)	$ 71,514	$ 73,562	$ 69,011
NET OPERATING INCOME (LOSS)	$ (4,687,595)	$ 384,132	$ 2,156,595
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	$ -	$ -	$ -
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ (4,687,595)	$ 384,132	$ 2,156,595

HISTORICAL DATA CHART

Give information for the last three (3) years for which complete data are available for the facility or agency. The fiscal year begins in Oct (Month)

	Year 2011	Year 2010	Year 2009
A. Utilization Date (I/P Discharges)	626	803	988
B. Revenue from Services to Patients			
1. Inpatient Services	$ 27,202,752	$ 27,084,006	$ 30,408,795
2. Outpatient Services	20,342,431	17,892,649	17,439,303
3. Emergency Serivces			
4. Other Operating Revenue (specify) _____	2,468,369	2,755,414	2,732,616
Gross Operating Revenue	$ 50,013,552	$ 47,732,069	$ 50,580,714
C. Deductions from Gross Operating Revenue			
1. Contractual Adjustments	26,942,525	27,731,909	34,538,860
2. Provision for Charity Care	671,102	597,561	790,432
3. Provision for Bad Debt	789,805	1,218,863	722,151
Total Deductions	28,403,432	29,548,333	36,051,443
NET OPERATING REVENUE	$ 21,610,120	$ 18,183,736	$ 14,529,271
D. Operating Expenses			
1. Salaries and Wages	14,182,257	14,174,718	14,780,456
2. Physician's Salaries and Wages			
3. Supplies	5,008,485	4,767,964	4,629,463
4. Taxes	148,604	919,223	
5. Depreciation	1,746,407	1,732,116	1,559,236
6. Rent			
7. Interest, other than Capital	38,221	46,043	40,018
8. Other Expenses Professional Fees, Utilities	1,245,862	1,241,040	1,140,241
Total Operating Expenses	$ 22,369,836	$ 22,881,104	$ 22,149,414
E. Other Revenue (Expenses) - Net (Specify)	120,802	122,378	113,153
NET OPERATING INCOME (LOSS)	$ (638,914)	$ (4,574,990)	$ (7,506,990)
F. Capital Expenditures			
1. Retirement of Principal			
2. Interest			
Total Capital Expenditures	0	0	0
NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ (638,914)	$ (4,574,990)	$ (7,506,990)

SUPPLEMENTAL- # 1
December 27, 2012
2:41pm

PROJECTED DATA CHART

2012 DEC 27 PM 2:52

Give information for the last two (2) years following the completion of this proposal.
The fiscal year begins in July (Month)

	Year 1	Year 2
A. Utilization Date (Inpatient Discharges/inpatient days)	785 / 11,095	1061 / 15,006
B. Revenue from Services to Patients		
1. Inpatient Services	$ 31,440,690	$ 43,374,038
2. Outpatient Services		
3. Emergency Serivces		
4. Other Operating Revenue (specify) cafeteria	$ 66,566	$ 93,132
Gross Operating Revenue	$ 31,507,256	$ 43,467,170
C. Deductions from Gross Operating Revenue		
1. Contractual Adjustments	$ 17,867,773	$ 24,390,358
2. Provision for Charity Care	$ 259,707	$ 357,210
3. Provision for Bad Debt	$ 162,755	$ 227,710
Total Deductions	$ 18,290,235	$ 24,975,278
NET OPERATING REVENUE	$ 13,217,021	$ 18,491,892
D. Operating Expenses		
1. Salaries and Wages	$ 7,297,025	$ 8,869,732
2. Physician's Salaries and Wages	$ 125,000	$ 125,000
3. Supplies	$ 904,220	$ 1,163,265
4. Taxes	$ 440,067	$ 448,868
5. Depreciation	$ 351,208	$ 457,210
6. Rent	$ 1,568,812	$ 1,604,110
7. Interest, other than Capital		
8. Management Fees:		
a. Fees to Affilitates	$ 490,000	$ 935,980
b. Fees to Non-Affilitates	$ 75,000	$ 76,500
9. Other Expenses (Specify on separate page)	$ 2,341,686	$ 2,305,922
Total Operating Expenses	$ 13,593,018	$ 15,986,587
E. Other Revenue (Expenses) - Net (Specify)		
NET OPERATING INCOME (LOSS)	$ (375,997)	$ 2,505,305
F. Capital Expenditures		
1. Retirement of Principal		
2. Interest		
Total Capital Expenditures	$ -	$ -
LESS CAPITAL EXPENDITURES	$ (375,997)	$ 2,505,305

HISTORICAL DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2009	Year 2010	Year 2011
Purchased Services	$ 367,151	$ 193,375	$ 246,949
Insurance	$ 14,229	$ (555)	$ (29,498)
Repairs & Maintenance	$ 207,529	$ 262,826	$ 316,174
Utilities	$ 451,342	$ 304,641	$ 308,130
Other	$ 237,054	$ 207,109	$ 207,519
Professional	$ 273,314	$ 245,182	$ 245,667
Total Other Expenses	**$ 1,550,619**	**$ 1,212,578**	**$ 1,294,941**

PROJECTED DATA CHART-OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 1	Year 2
a. Utilities	468,118	503,410
b. Legal Fees and Other Professional Fees	477,485	45,918
c. Audit/Accounting Fees	33,285	45,918
d. Repairs and Maintenance	8,321	11,480
e. Registry/Temp Labor	110,950	153,062
f. Collection Agency	5,548	7,653
g. Printing	5,000	5,100
h. Bank Fees, Misc Service Charges	2,000	2,040
i. Continuing Education	11,095	15,306
j. Recruiting	69,190	30,612
k. Operating Room	42,938	59,235
l. Respiratory Therapy	55,475	76,531
m. Diagnostic Radiology	166,425	229,592
n. Laboratory	277,375	382,653
o. EKG	14,978	20,663
p. Renal Dialysis	11,095	15,306
q. Laundry & Linen	55,475	76,531
r. Other Fixed Costs	180,000	183,600
s. Other Variable Costs	110,950	153,061
t. Equipment Rental	110,950	153,061
u. Malpractice and Liability Insurance, base	35,000	35,700
v. Malpractice and Liability Insurance, variable	72,118	99,490
w. Other (Misc. Start-up Costs)	17,915	-
Total Other Expenses	2,341,686	2,305,922

6. A. Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.

Response

The charge schedules will not change from the implementation of this proposal. The current charges at Baptist Rehabilitation -Germantown and at the new Baptist Memorial Rehabilitation Hospital will be the same.

B. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

Response

There are 2 freestanding HealthSouth facilities in the service area for which comparisons can be made. Below, year 1 projections for the proposed new hospital are compared to the most recent Joint Annual Reports of those 2 facilities:

Figure C: Economic Feasibility.6.B

Projected Charges Year 1 Compared to Most Recently Reported Charges of Similar Facilities

	Cases	Days	Gross Charges	Net Charges	Gross/Case	Gross/Day	Net/Case	Net/Day
HealthSouth Memphis (2011)	1,582	19,433	$ 43,818,888	$ 25,023,939	$ 27,698	$ 2,255	$ 15,818	$ 1,288
HealthSouth North Memphis (2011)	1,073	13,666	$ 25,252,390	$ 18,422,369	$ 23,534	$ 1,848	$ 17,169	$ 1,348
Proposed Project (Year 1)	785	11,095	$ 31,440,690	$ 13,217,021	$ 40,062	$ 2,834	$ 16,841	$ 1,191

Source: Joint Annual Reports, Projected Data - Inpatient Data Only, Mature Area Facilities versus Proposed Hospital Year 1 Data

7. Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.

Response

Implementation of the project will not result in an increase of the charges to the patient. The projected data charts demonstrate that the new rehabilitation hospital will have positive income. The utilization rates will increase due to the new hospital having all private rooms and having specialized stroke/neurological programs. This will create economies of scale and efficiencies that will allow the hospital to spread its fixed costs over a larger number of patient days, thus reducing the cost per patient day.

8. Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.

Response

Baptist Memorial has a large number of patients who are appropriate for inpatient rehabilitation (See Section C, Need - Question 6). It seems certain that the proposed hospital (with all private rooms and specialized programming) will be sufficiently utilized in its first two years to operate with a strong financial margin. The applicant will have sufficient resources to support hospital operations as it builds census while acquiring Medicare certification.

9. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.

Response
The proposed inpatient rehabilitation hospital will follow the ERDs and charity care policy of Baptist Memorial Health Care Corporation.

Figure C: Economic Feasibility.C.9

Medicare and TennCare/Medicaid Gross Revenue
Year 1

Category	Gross Revenue	% of Gross
Medicare	$ 18,864,414	60.0%
TennCare/Medicaid	$ 1,257,628	4.0%

10. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.

Response
The initial operating capital and moveable equipment costs are Centerre's contribution to the partnership. Centerre Healthcare Audited Financial Statements with notes. are provided as Attachment C Economic Feasibility 10.

11. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

a. A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.

b. The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable.

Response:

One option was to maintain the operations as currently provided at Baptist Rehabilitation - Germantown. Providing more rehabilitative services for the complex neuro patients is an increasing need that could not be effectively addressed. Providing accommodations in all rooms for ADA accessibility through periods of disability and privacy is also a need for patient and family satisfaction with the inpatient experience. Decreasing admissions to the facility also reflect concern with the available facility. This option did not effectively address the need.

Another option considered was the possibility of adding to the existing structure. Any significant expansion is prevented by building regulations and the availability of land. The current base of the facility cannot reasonably be extended. Height restrictions and the current building structure prevent vertical expansion on the current campus. Expansion at the current location is not a feasible solution.

Internal renovation was also considered , but the building size will not permit private rooms unless the total bed availability is reduced which would be less than the need supported by discharges from the Baptist facilities alone. ADA compliance also would not be reasonable in every patient room.

The option that was chosen as the most feasible is the subject of this CON application. By relocating inpatient rehabilitation facility beds that are already in the community, the service remains matched to the needs of the area. The partnership formed by Baptist Memorial Health Care and Centerre Healthcare will offer the inpatient service in a new, state-of-the-art 49 bed freestanding inpatient hospital with all private rooms.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

   Response

   The proposed new hospital, being a joint venture between Centerre Healthcare and Baptist Memorial, will continue relationships with entities throughout the Baptist system and other providers in the community. The inpatient rehabilitation hospital will serve the same populations and will have electronic capabilities to reinforce communications with referring physicians and professionals across the region.

   Access for area physicians and patients will continue without interruption. The new inpatient rehabilitation hospital will be available to any qualified physician who applies and receives privileges.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

   Response

   The proposed new hospital will positively affect the health care system. The new private rooms will accommodate more patients effectively and efficiently without adding additional beds to the system.

   As described in other sections, increasing the capabilities and scope of specialized programs for stroke/neurological conditions will provide a greater level of rehabilitative care for complex patients which will grow with the projected 35% increase in the 65 and over population in Shelby County over the next 9 years. The specialized programming (e.g. CARF accredited stroke/ brain injury) and the increased number of private rooms will create a "Center of Excellence" for the community.

   The proposed hospital will be an improvement in the capabilities of existing services and will not duplicate services or adversely affect other providers in the area.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Response

TITLE	End of Year 1*	End of Year 2
	FTE	FTE
Nursing		
RN's	19.8	20.3
LPN's	12.9	13.2
Aides	17.1	17.6
Charge Nurse	4.2	4.2
Total Nursing FTE's	54.0	55.3
Total Paid Nursing FTE's	61.5	62.9
Therapy		
Physical Therapists	6.3	6.3
PTA	3.0	3.0
Occupational Therapists	5.5	6.0
COTA	3.0	3.0
Techs	-	-
SLPs	3.0	3.0
Total Therapy FTE's	20.8	21.3
Total Paid Therapy FTE's	23.6	24.2

Tennessee Department of Labor and Workforce Development: Memphis, TN-MS-AR MSA Available Salaries

Occupation	Entry Wage	Median	Mean	Experienced	BMHCC Median
Registered Nurses	$49,030	$61,050	$65,950	$74,420	$30.08
Nursing Aides, Orderlies & Attendants	$18,660	$22,630	$23,110	$25,330	$12.90
Physical Therapists	$65,010	$82,640	$85,190	$95,280	$40.00
Physical Therapist Assistants	$43,890	$62,260	$58,680	$66,080	$30.00
Occupational Therapists	$56,750	$74,960	$74,430	$83,270	$40.00
Occupational Therapist Assistants	$44,820	$62,680	$58,660	$65,580	$30.00
Speech-Language Pathologists	$47,400	$62,610	$65,160	$74,050	$40.00
Pharmacists	$93,900	$119,930	$115,430	$126,190	$53.19
Pharmacy Aides	$18,460	$23,200	$23,480	$25,980	$17.27
Healthcare Support Workers, All Other	$22,190	$28,170	$30,380	$34,480	$17.97

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Response

Most of the positions are already actively involved in the current hospital or working elsewhere in the Baptist Memorial Health Care system. Trained and qualified human resources are accessible for the proposed project.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

Response

The applicant understands requirements and regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review policies and programs, record keeping and staff education.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).

Response

Baptist Memorial Health Care Corporation and Baptist Rehabilitation - Germantown are strong supporters of educational opportunities throughout the region. Baptist's Philosophy and Mission for the system states that, "... it seeks to ENCOURAGE, GUIDE, and INSTRUCT those individuals entering into professions related to the healing of the body, mind and spirit."

Baptist Memorial College of Health Sciences was chartered in 1994 as a specialized college offering baccalaureate degrees in nursing and in allied health sciences as well as continuing education opportunities for healthcare professionals.

The four year BHS degree includes radiology training in areas of radiation therapy, nuclear medicine, diagnostic medical services, and radiographic technology.

7. (a) Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.

Response
Baptist Rehabilitation - Germantown has reviewed and understands the licensure requirements of the Department of Health and applicable Medicare requirements.

(b) Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: Tennessee Department of Health

Accreditation: Joint Commission ; CARF

(c) If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.

Response
Although the proposed project involves a new facility that has not been licensed, the current license of Baptist Rehabilitation -Germantown, that is the current location of the inpatient rehabilitation beds, is provided for reference.

(d) For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.

Response
Although the proposed project involves a new facility the most recent completed licensure/certification survey for Baptist Rehabilitation-Germantown with is included as an attachment.

8. Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.

Response
There are no final orders or judgments to report for Baptist Rehabilitation -Germantown.

9. Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project

Response
There are no final civil or criminal judgments to report for either partner - Centerre or Baptist Memorial.

10. If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.

Response

The applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and any other data as required.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

Response

A page from the Commercial Appeal is provided.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.
2. If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

DEC 14 PM 3 08

The Commercial Appeal
Affidavit of Publication

STATE OF TENNESSEE
COUNTY OF SHELBY

Personally appeared before me, Patrick Maddox, a Notary Public, Helen Moriarty, of MEMPHIS PUBLISHING COMPANY, a corporation, publishers of The Commercial Appeal, morning and Sunday paper, published in Memphis, Tennessee, who makes oath in due form of law, that she is Legal Clerk of the said Memphis Publishing Company, and that the accompanying and hereto attached notice was published in the following edition of The Commercial Appeal to-wit:

December 10, 2012

Helen Moriarty

Subscribed and sworn to before me this 10th day of December, 2012

Patrick Maddox Notary Public

My commission expires 2/15/16

PATRICK MADDOX
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

My Commission Expires 02/15/2016

holders:
s Roebuck and
pany
Jason O. Young
Peabody Avenue # 2
mphis, TN 38104
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les: N/A
sale is subject to liens;
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its of redemption of
ing entities; all matters
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high bidder fails to close
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shall have the option of
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may be rescinded at
Successor Trustee's
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e a new notice of sale.
sman Nowack Curry
llco, PC
Alliance Center,
Floor
Lenox Road
nta, GA 30326
960-8298
#: 015247

NOTICE OF
FORECLOSURE SALE
DISON COUNTY,
TE OF TENNESSEE
IS AN ATTEMPT TO
LLECT A DEBT. ANY
FORMATION OB-
INED WILL BE USED
R THAT PURPOSE.
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terms, conditions and
ments provided for in
t certain Deed of Trust
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ord in Deed Book /
ge Number T1744 / 948,
trument 06004523, Reg-
r's Office for Madison
unty, Tennessee, from

filing; any matter that an accurate survey of the premises might disclose; and other matters which are prior in right to the lien of the aforesaid Deed of Trust.
If a high bidder fails to close a sale, the Successor Trustee shall have the option of making the sale to the next highest bidder. The sale held pursuant to this Notice may be rescinded at the Successor Trustee's option at any time. The right is reserved to adjourn the sale to another day, time and/or place certain without further publication, upon announcement at the time and place for the sale set forth above, or at any date and time fixed by a preceding postponement. Alternatively, at its option, Successor Trustee may give a new notice of sale.
Weissman Nowack Curry & Wilco, PC
One Alliance Center,
4th Floor
3500 Lenox Road
Atlanta, GA 30326
(866) 960-8298
File#: 014190

NOTICE OF
FORECLOSURE SALE
SHELBY COUNTY,
STATE OF TENNESSEE
THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.
Default has been made in the terms, conditions and payments provided for in that certain Deed of Trust dated August 25, 2005, of record in Deed Instrument 05142476, Register's Office for Shelby County, Tennessee, from Sylvia Gantt and Timothy Gantt (Borrower) to NETCO INC (Trustee) for the benefit of NEW CENTRUY MORTGAGE CORPORATION (Lender), securing the Note/Indebtedness therein described, the entire Note/Indebtedness having been declared in default and immediately due and payable by the lawful owner and holder thereof.
DEUTSCHE BANK NATIONAL TRUST COMPANY, AS TRUSTEE FOR NEW CENTURY HOME EQUITY LOAN TRUST, SERIES 2005-B, ASSET BACKED PASS-THROUGH CERTIFICATES (Holder), now being the present owner/holder of said Indebtedness, has now re-

NOTIFICATION OF INTENT
O APPLY FOR A CERTIFICATE OF NEED

is to provide official notice to the Health Services and Development ncy and all interested parties, in accordance with T.C.A. Sections 11-1601 et seq., and the Rules of the Health Services and elopment Agency, that Select Specialty Hosptial-Memphis (a long acute care hospital), owned and managed by Select Specialty pital-Memphis, Inc. (a corporation), intends to file an application Certificate of Need to add twenty-eight (28) long term acute care s to its facility, located in leased space at St. Francis Hospital, 5959 Avenue, Memphis, TN 38119. The project cost for CON purposes stimated at $6,900,000. The project contains no major medical ipment and does not add or discontinue any new health service.

ect Specialty Hospital is currently licensed by the Board for nsing Healthcare Facilities (TN Department of Public Health) thirty-nine (39) long term acute care beds. Select Specialty has ived State approval for licensure of ten (10) additional long term te care beds without CON review, under a statutory exemption lable to hospitals of fewer than 100 beds. Upon its implementation, ect will be licensed for forty-nine (49) long term acute care beds, so the twenty-eight (28) bed expansion proposed in this Certificate of d application would increase the Select license to seventy-seven long term acute care beds. St. Francis Hospital, which is leasing se beds to Select, will reduce its current 519-bed general hospital nse by 10 beds to reflect the approved 10-bed expansion of Select ugh the CON exemption process, and will reduce its license by 28 e beds if this CON application is approved. The net effect of these nges will be that the project will not change the service area's total ised complement of general acute care plus long term acute care pital beds.

anticipated date of filing the application is on or before December 2012. The contact person for the project is John Wellborn, who may eached at Development Support Group, 4219 Hillsboro Road, Suite , Nashville, TN 37215; (615) 665-2022.

n written request by interested parties, a local Fact-Finding public ing shall be conducted. Written requests for hearing should be sent to:

alth Services and Development Agency, Andrew Jackson Building, 500 Deaderick Street, Suite 050, Nashville, Tennessee 37243

suant to TCA Sec. 68-11-1607(c)(1): (A) any health care institution ring to oppose a Certificate of Need application must file a written ection with the Health Services and Development Agency no later fifteen (15) days before the regularly scheduled Health Services Development Agency meeting at which the application is originally eduled, and (B) any other person wishing to oppose the application st file written objection with the Health Services and Development ncy at or prior to the consideration of the application by the Agency.

ternatively, at its option, Successor Trustee may give a new notice of sale.
Weissman Nowack Curry & Wilco, PC
One Alliance Center,
4th Floor
3500 Lenox Road
Atlanta, GA 30326
(866) 960-8298
File #: 015188

NOTICE OF
FORECLOSURE SALE
SHELBY COUNTY,
STATE OF TENNESSEE
THIS IS AN ATTEMPT TO COLLECT A DEBT. ANY INFORMATION OBTAINED WILL BE USED FOR THAT PURPOSE.
Default has been made in the terms, conditions and payments provided for in that certain Deed of Trust dated June 29, 2004, of record in Deed Instrument 04111900 (rerecorded at 04132362), Register's Office for Shelby County, Tennessee, from Sherry Denise Bass and Dennis Glenn Bass (Borrower) to TITLE ENTERPRISES LLC (Trustee) for the benefit of NEW CENTURY MORTGAGE CORPORATION (Lender), securing the Note/Indebtedness therein described, the entire Note/Indebtedness having been declared in default and immediately due and payable by the lawful owner and holder thereof.
U.S. BANK N.A.,IN ITS CAPACITY AS TRUSTEE FOR THE REGISTERED HOLDERS OF ASSET BACKED SECURITIES CORPORATION, HOME EQUITY LOAN TRUST 2004-HE6, ASSET BACKED PASS-THROUGH CERTIFI-

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that, Baptist Memorial Rehabilitation Hospital, G.P., a general partnership consisting of Baptist Memorial Health Services, Inc., an affiliate of Baptist Memorial Health Care Corporation and CRH of Memphis, LLC, an affiliate of Centerre Healthcare Corporation with an ownership type of partnership and to be managed by CHC Management Services, LLC, intends to file an application for a Certificate of Need to establish a rehabilitation hospital consisting of 49 beds. The hospital will be located in approximately 59,400 sq ft of space to be constructed at 1238 and 1280 South Germantown Parkway, Germantown Tennessee 38138. The location is close to the intersection of Germantown Parkway and Wolf River Boulevard in Germantown, Tennessee. Simultaneously with the implementation of the new hospital, Baptist Rehabilitation Hospital- Germantown would delicense the 49 bed Rehabilitation unit located at 2100 Exeter Road Germantown, Tennessee 38138 which is approximately 2.5 miles from the new site. The project does not involve the addition of beds or any other service for which a certificate of need is required. The estimated project cost is $33,167,900. The anticipated date of filing the application is December 14, 2012. The contact person for this project is Arthur Maples, Dir. Strategic Analysis, who may be reached at Baptist Memorial Health Care Corporation, 350 N. Humphreys Blvd, Memphis, TN 38120, (901) 227-4137.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted.
Written requests for hearing should be sent to:
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243
The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

PROJECT COMPLETION FORECAST CHART

2012 DEC 14 PM 3 08

Enter the Agency projected Initial Decision date, as published in T.C.A. § 68-11-1609(c): 03/27/2013

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	DAYS REQUIRED	Anticipated Date (MONTH/YEAR)
1. Architectural and engineering contract signed	5	04/2013
2. Construction documents approved by the Tennessee Department of Health	110	07/2013
3. Construction contract signed	110	07/2013
4. Building permit secured	120	07/2013
5. Site preparation completed	180	09/2013
6. Building construction commenced	180	09/2013
7. Construction 40% complete	300	01/2014
8. Construction 80% complete	420	05/2014
9. Construction 100% complete (approved for occupancy	480	07/2015
10. *Issuance of license	510	08/2014
11. *Initiation of service	511	08/2014
12. Final Architectural Certification of Payment	510	09/2014
13. Final Project Report Form (HF0055)	600	11/2014

* **For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

2012 DEC 14 PM 3 08

STATE OF Tennessee

COUNTY OF Shelby

Arthur Maples, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Arthur Maples, Dir Strategic Analysis
SIGNATURE/TITLE

Sworn to and subscribed before me this 13th day of December (Month) 2012 (Year) a Notary

Public in and for the County/State of Shelby/TN.

Paulette E. Kearney
NOTARY PUBLIC

My Comm. Exp. August 21, 2016

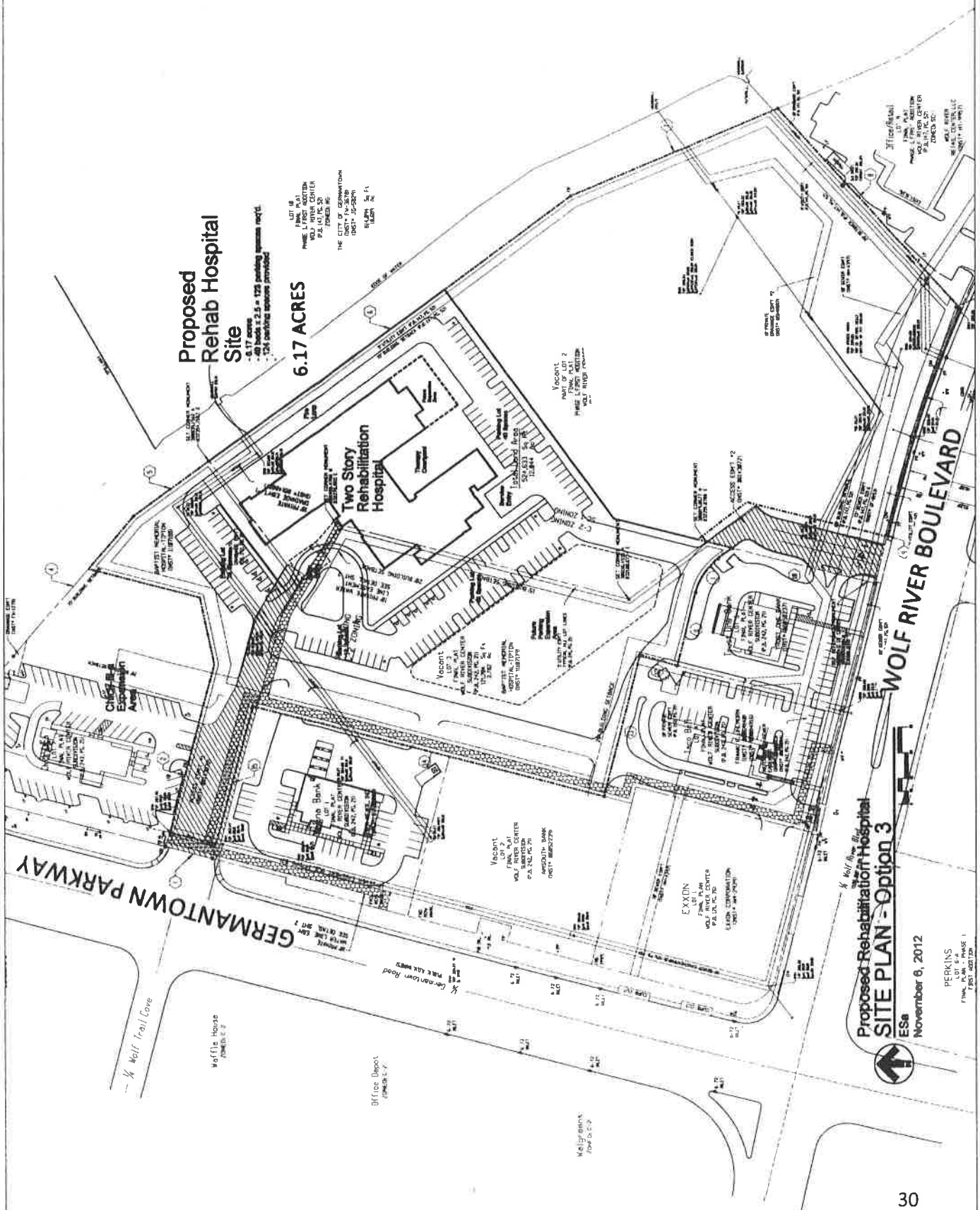
My commission expires _____ (Month/Day), _____ (Year).

PAULETTE E. KEARNEY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

INDEX OF ATTACHMENTS

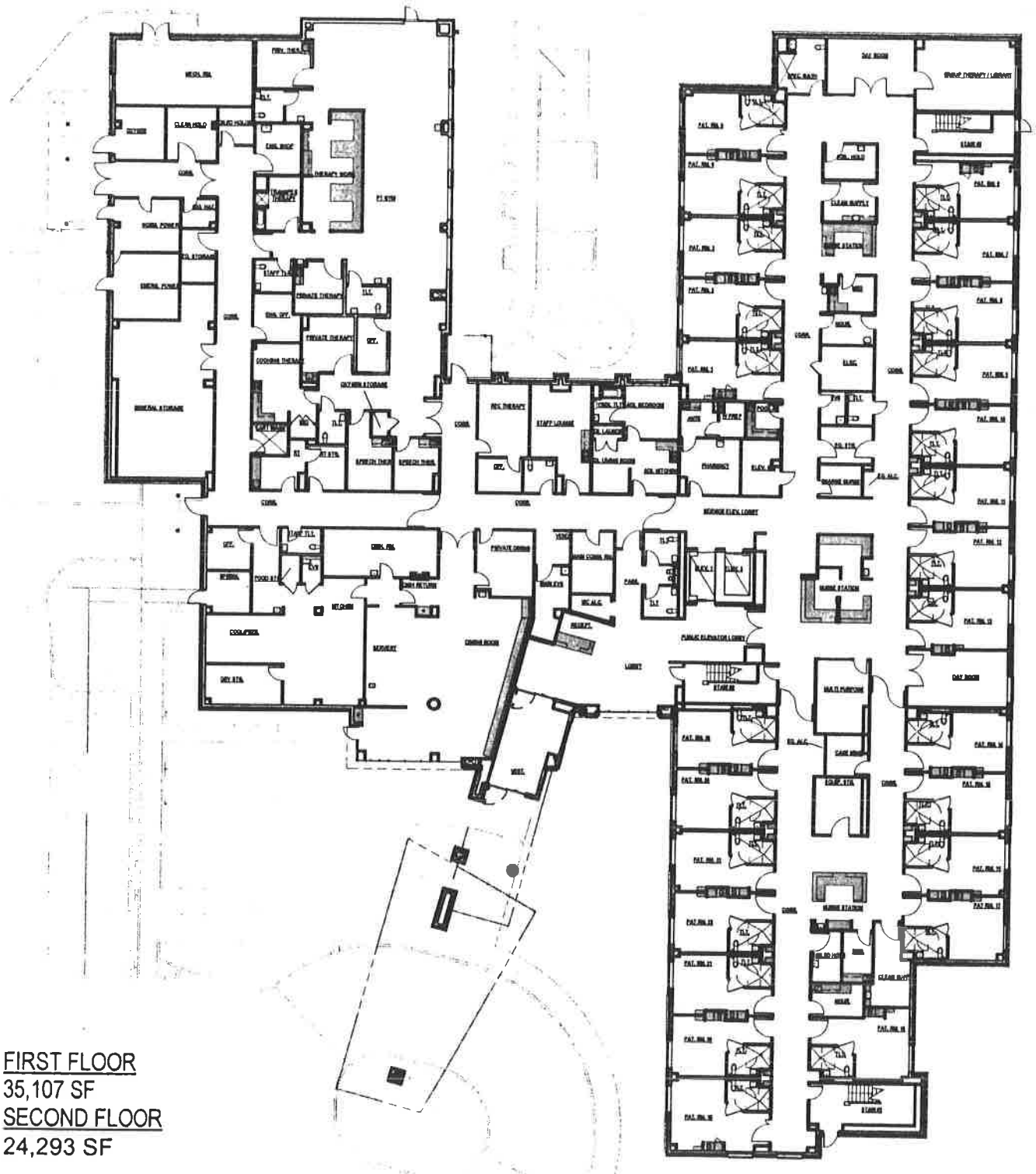
Plot Plan

Section B, III, A (1)


Proposed
Rehab Hospital
Site
6.17 ACRES
Two Story
Rehabilitation
Hospital
WOLF RIVER BOULEVARD
GERMANTOWN PARKWAY
Proposed Rehabilitation Hospital
SITE PLAN - Option 3
ESa
November 6, 2012

Floor Plan

Section B, IV



FIRST FLOOR
35,107 SF
SECOND FLOOR
24,293 SF

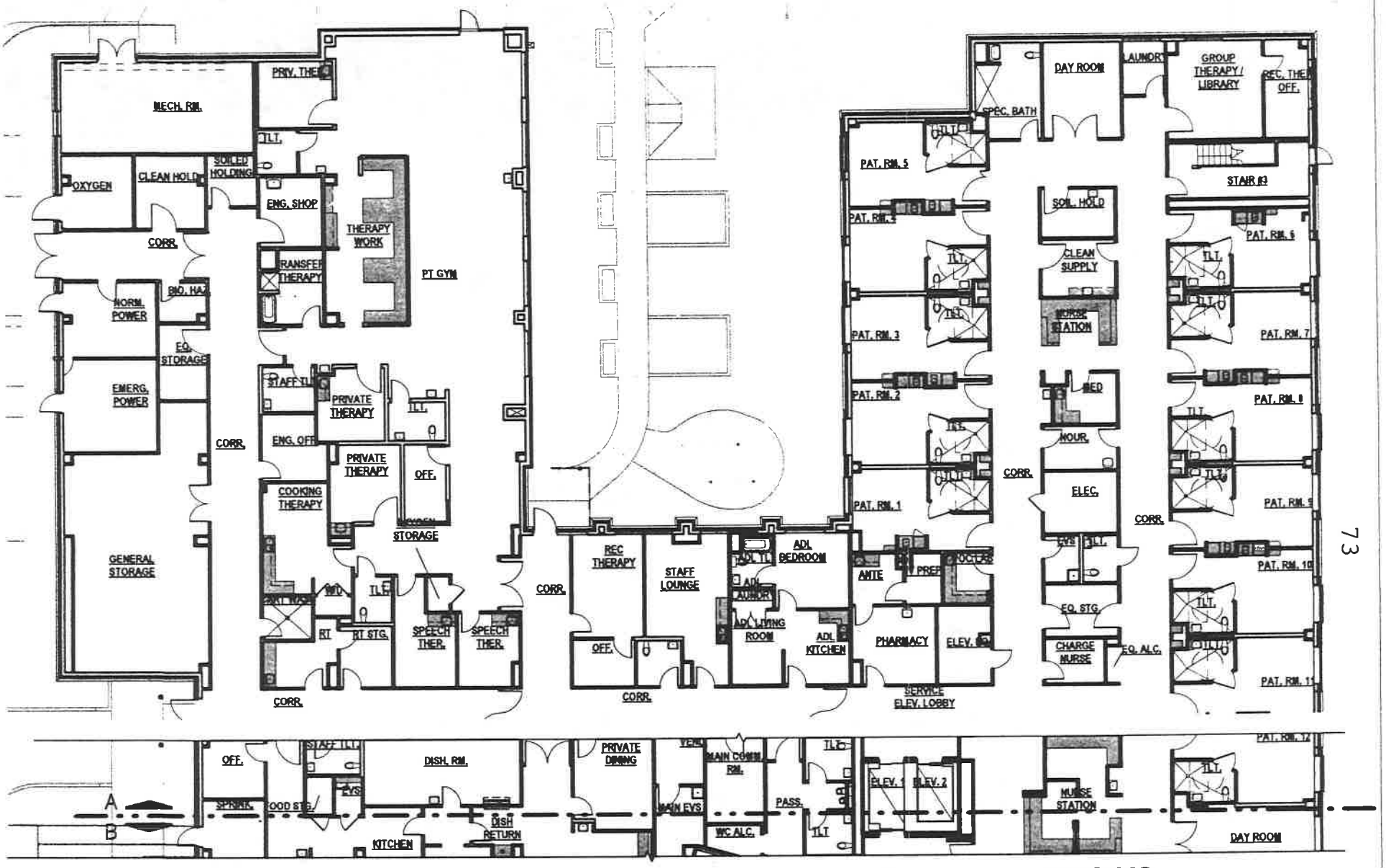
TOTAL SF
59,400 SF

0 8' 16' 32' 64'

ESa
12161.00

PROPOSED REHABILITATION HOSPITAL

GERMANTOWN, TENNESSEE
FIRST FLOOR 10/25/12



73

FIRST FLOOR- PART A

FIRST FLOOR
35,103 SF

SECOND FLOOR
24,297 SF

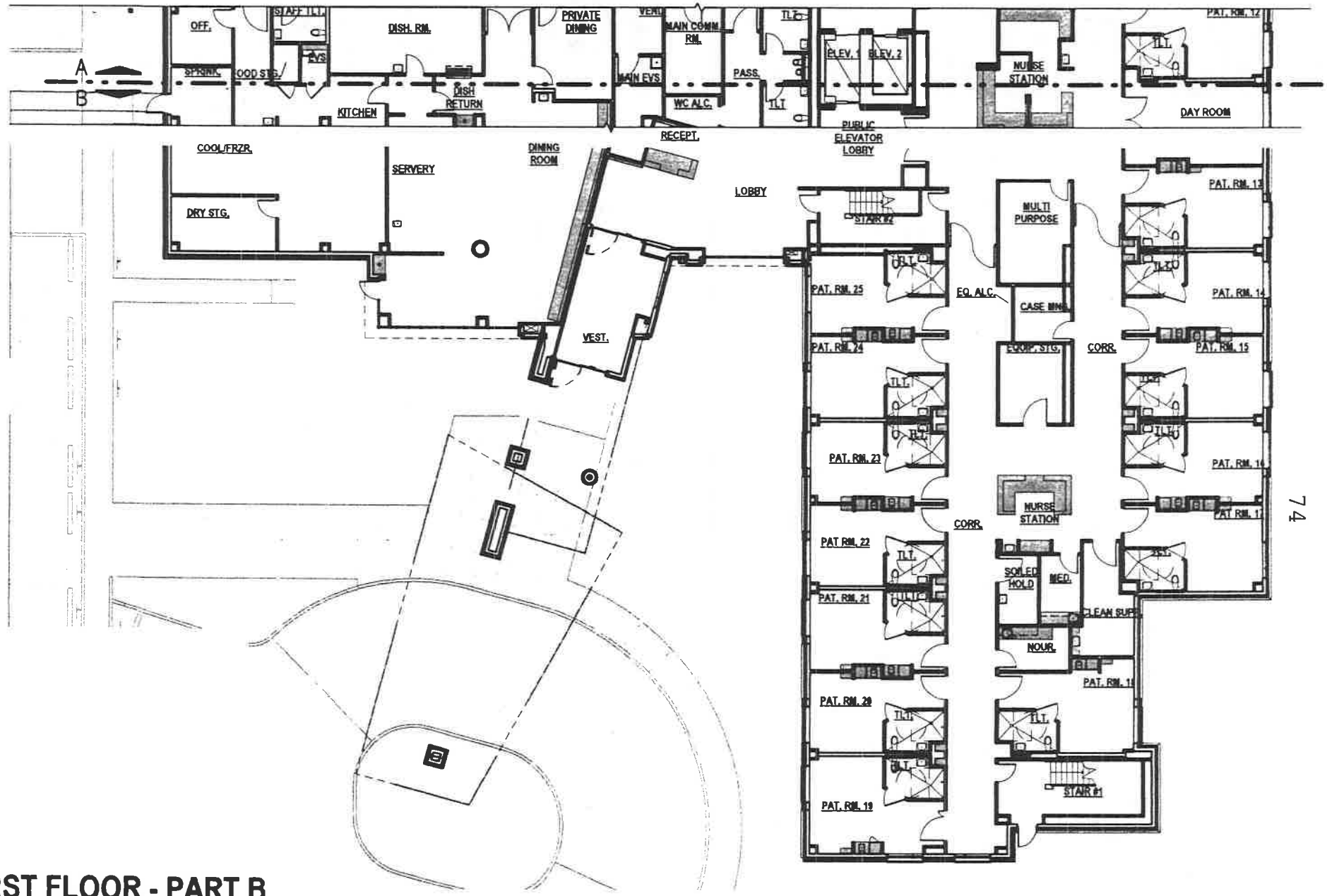
TOTAL SF
59,400 SF

ESa
12161.00

GERMANTOWN REHABILITATION HOSPITAL

GERMANTOWN, TENNESSEE

FIRST FLOOR PART A 10/26/12



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FIRST FLOOR - PART B

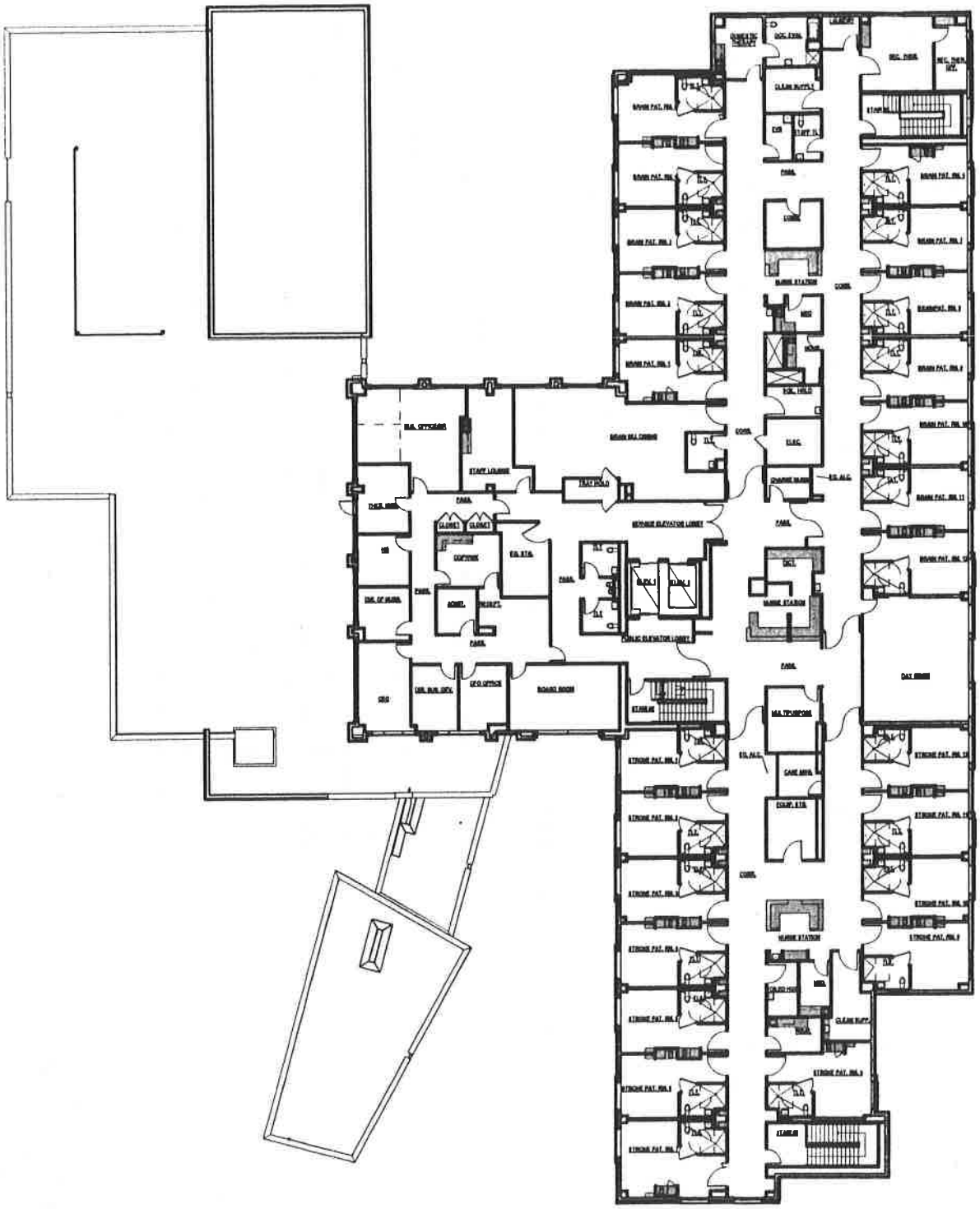
ESa

12161.00

GERMANTOWN REHABILITATION HOSPITAL

GERMANTOWN, TENNESSEE

FIRST FLOOR PART B 10/25/12



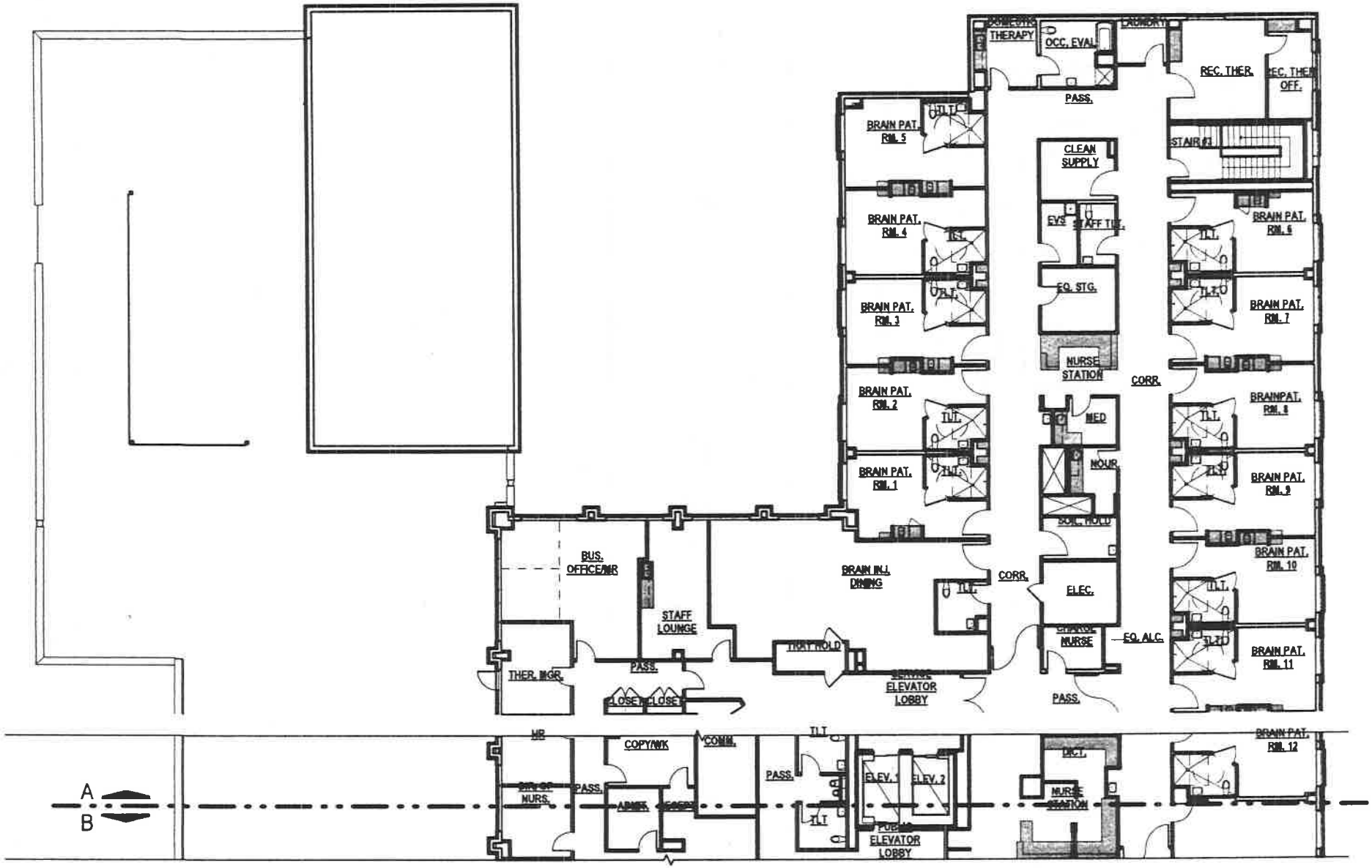
SECOND FLOOR
24,293 SF

0 8' 16' 32' 64'

ESa
12161.00

PROPOSED REHABILITATION HOSPITAL

GERMANTOWN, TENNESSEE
SECOND FLOOR 10/25/12



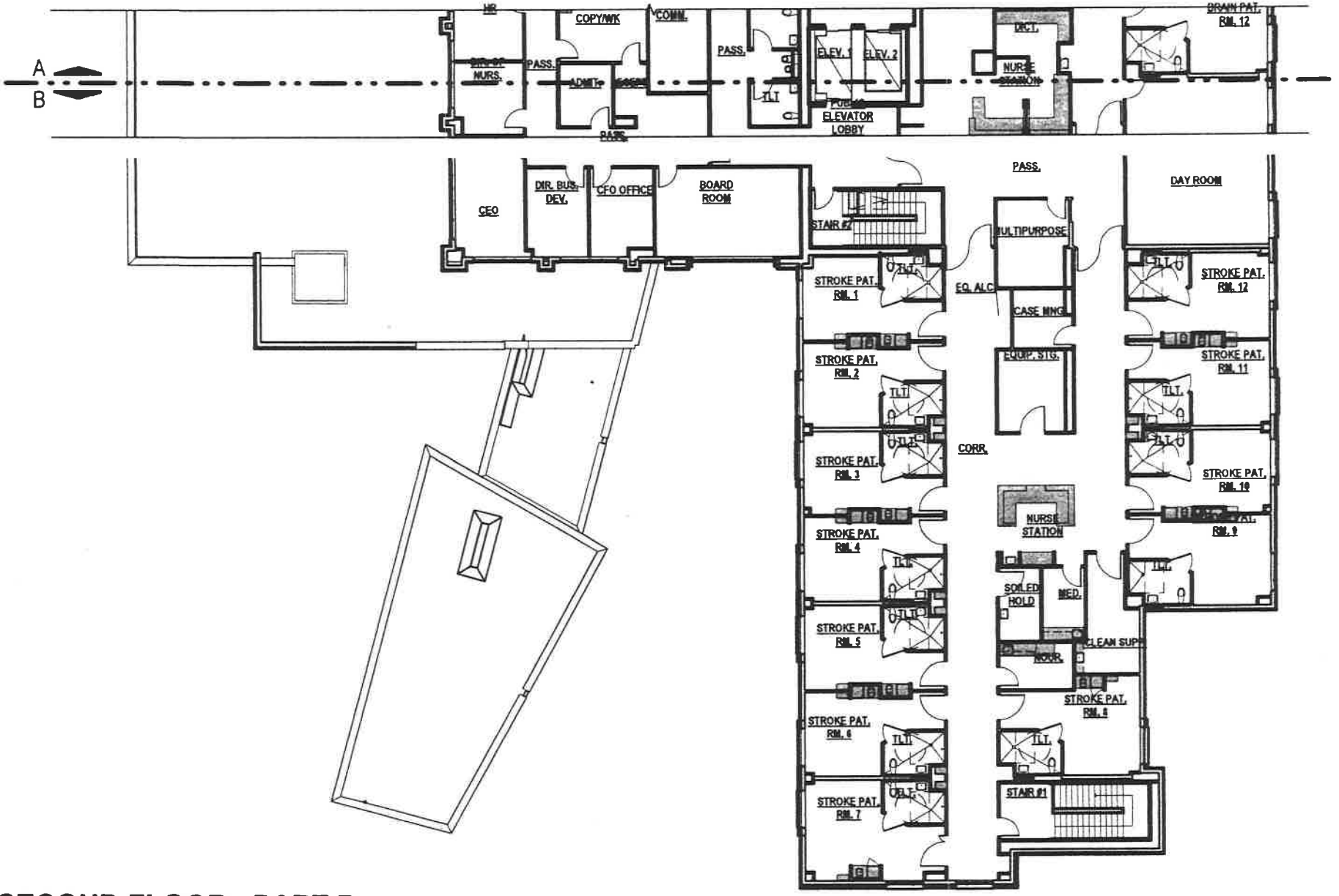
SECOND FLOOR - PART A

SECOND FLOOR
24,297 SF

ESa
12161.00

GERMANTOWN REHABILITATION HOSPITAL

GERMANTOWN, TENNESSEE
SECOND FLOOR - PART A 10/26/12



SECOND FLOOR - PART B

77

ESa
12161.00

GERMANTOWN REHABILITATION HOSPITAL

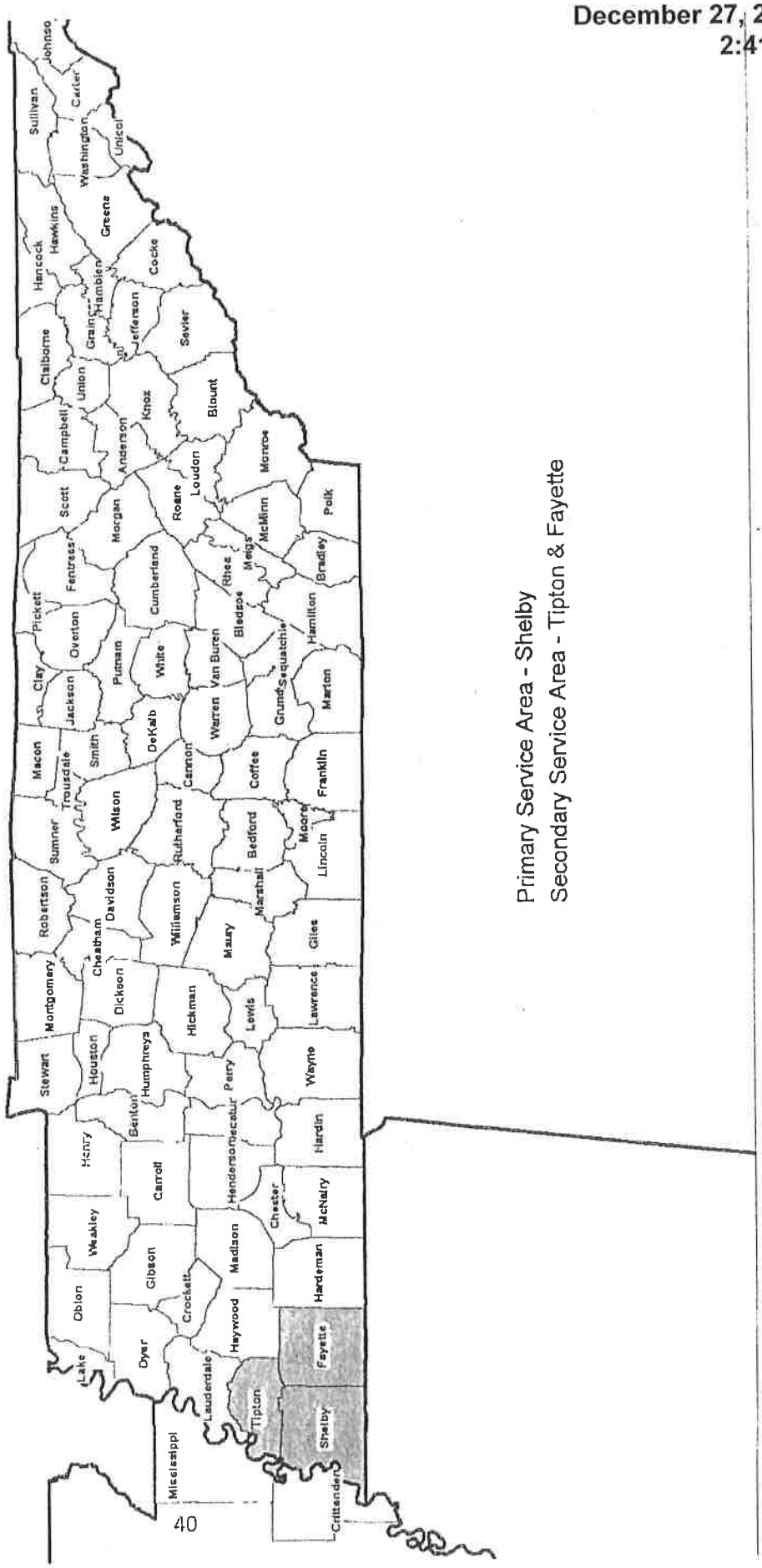
GERMANTOWN, TENNESSEE

SECOND FLOOR - PART B *NOT USED*

Service Area Map

Section C, 3

SUPPLEMENTAL- # 1
December 27, 2012
2:41pm



CMS 60% Rule

Section C, Need 6

60% Rule: CMS 13

2

HCFA 10

1. Stroke
2. Brain Injury
3. Amputation
4. Spinal Cord
5. Fracture of Femur
6. Neurological Disorders
7. Multiple Trauma
8. Congenital Deformity
9. Burns

Same As HCFA-10 →

CMS 13

1. Stroke
2. Brain Injury
3. Amputation
4. Spinal Cord
5. Fracture of Femur
6. Neurological Disorders
7. Multiple Trauma
8. Congenital Deformity
9. Burns

10. Polyarthritis

Replaced by new categories (10-12) →

10. Osteoarthritis (after less intensive setting)
11. Rheumatoid Arthritis (after less intensive)
12. **Joint Replacement**
    - **Bilateral**
    - **Age >85**
    - **BMI >50**

13. Systemic Vasculidities (after less intensive setting)

2004 MC Reform in IRF criteria became more stringent for Joint Replacement and Ortho cases
Classified as IRF if admit 60% of cases in 13 conditions

Rehabilitation Classification System

3

Rehabilitation Impairment Categories (RIC)

IRF-PPS Patient Classification System

Applies to 60% rule

1. Stroke
2. Traumatic Brain Injury
3. Non-Traumatic Brain Injury
4. Traumatic Spinal Cord Injury
5. Non-Traumatic SCI
6. Neurological
7. Lower Ext Fracture
8. Amputation – Lower Extremity
9. Amputation – Other
10. Maj Multi Trauma wo BI/SC
11. Maj Multi Trauma w BI or SC
12. Guilliam Barre
13. Burns

Must qualify or does not apply to 60% rule

14. Lower Ext Jt Replacement
15. Other Orthopedic
16. Osteoarthritis
17. Rheumatoid
18. Cardiac
19. Pulmonary
20. Pain
21. Miscellaneous (Debility and some medically complex)

Centerre <u>Methodology</u>:
conversion factors much higher for these cases - bed need calculation heavily reliant on compliant cases (see appendix for methodology explanation and bed need calculation)

Architect Letter

Economic Feasibility 1

October 26, 2012

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: GERMANTOWN REHABILITATION HOSPITAL
BAPTIST MEMORIAL HOSPITAL/CENTERRE HEALTHCARE
GERMANTOWN, TN
ESa PROJECT NO. 12161.00

Dear Ms. Hill:

This letter will affirm that, to the best of our knowledge, the design intended for the construction of the referenced facility will be in accordance with the following primary codes and standards as listed in the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities - Standards for Hospitals - Chapter 1200-8-1-.08:

- Current edition of FGI Guidelines for the Design and Construction of Healthcare Facilities.
- Current edition of Rules of Tennessee Department of Health and Environment Board for Licensing Healthcare Facilities.
- Current edition of the Standard Building Code.
- Current edition of the Standard Mechanical Code.
- Current edition of the Standard Plumbing Code.
- Current edition of the Standard Gas Code.
- Current edition of the National Fire Protection Code (NFPA 101).
- Current edition of the National Electrical Code.
- Current edition of the American's with Disabilities Act (ADA).
- Current edition of the North Carolina Handicap Code.
- Current edition of the US Public Health Service Code.

This listing may not be entirely inclusive, but the intent is for all applicable codes and standards, State or Local, to be addressed during the design process.

Best Regards,
EARL SWENSSON ASSOCIATES, INC.

Matthew A. Manning, AIA, NCARB, EDAC
Senior Project Manager

October 24, 2012

Ms. Melanie Hill
Executive Director
State of Tennessee
Health Services and Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Germantown Rehabilitation Hospital
Baptist Memorial Hospital/Centerre Healthcare
Germantown, TN
ESa Project No. 12161.00

Dear Ms. Hill:

This letter will denote that ESa has reviewed the site preparation and construction costs indicated as $883,932 and $14,539,872 for the referenced project and find the costs to be reasonable for the described scope of work. The construction costs have considered recent market conditions and inflation projections. We have also estimated Architectural and Engineering Fees of $905,851 for the project.

Best Regards,

Earl Swensson Assoc., Inc.

Matthew A. Manning, AIA, NCARB, EDAC
Senior Project Manager

Chief Financial Officer Letter

Economic Feasibility 2(E)

5250 Virginia Way
Suite 240
Brentwood, TN 37027
Office: 615-846-9500
Fax: 615-846-9585
www.centerrehc.com

October 24, 2012

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson State Office Building, Suite 850
500 Deaderick Street
Nashville, TN 37243

RE: Relocating 49 inpatient rehabilitation beds Baptist Rehabilitation Hospital – Germantown

Dear Ms. Hill:

As the Chief Financial Officer of Centerre Healthcare, I have reviewed the financial statements and requirements in the certificate of need application. The proposed hospital is a joint venture between Baptist Memorial and Centerre Healthcare. Baptist Memorial will be 55% owners and their contribution to the joint venture will be their existing inpatient rehabilitation business. Centerre Healthcare will be 45% owners and their contribution to the joint venture will be $7.04M in cash to fund operations (working capital and equipment). This was determined by an independent third party valuation firm.

Financial statements have been provided for Centerre Healthcare that accurately reflect the operations as audited by Lattimore Black Morgan & Cain (LBMC). Centerre Healthcare has the available resources to fund the proposed new 49-bed inpatient rehabilitation hospital. Additional statements for Centerre Healthcare that reflects the available resources can be provided if necessary.

Please contact me if you need additional information.

Sincerely,

David Canniff
Chief Financial Officer

Developer Document

Economic Feasibility 2(F)

DukeREALTY HEALTHCARE
[illegible] 96th Street
Suite 100
Indianapolis IN 46240
317 808 6900
www.dukerealty.com

December 12, 2012

Mr. Jason Little
Vice President
Baptist Memorial Health Services, Inc.
350 North Humphreys
Memphis, Tennessee 38210

RE: Proposed Development of Medical Office Building to be located in Memphis, Tennessee (the "Building")

Dear Jason:

The purpose of this Letter of Intent is to confirm the interest of Duke Realty Limited Partnership or one of its affiliates ("Duke Realty") to develop and construct the Building for the use and benefit of Baptist Memorial Rehabilitation Hospital, G.P., a Delaware general partnership ("BMRH") consistent with the provisions of the term sheet attached hereto as Exhibit A (the "Term Sheet").

While the terms and conditions set forth in the Term Sheet are good faith estimates by the parties in order to facilitate the preparation and filing of a certificate of need application by BMRH, the Term Sheet does not contain all of the critical terms of the proposed transaction and is subject to the conditions set forth therein including, among other things, the execution and delivery of all agreements described therein, all of which are subject to (i) the issuance by the Tennessee Health Services and Development Agency of a certificate of need for a 49 bed rehabilitation hospital at the location set forth in the Term Sheet, and (ii) approval by Duke Realty's Investment Committee.

Should you have any questions or concerns regarding this matter, please do not hesitate to call. We look forward to working with you to finalize the terms of this transaction.

Sincerely,

Deeni Taylor
Executive Vice President, Healthcare

ACKNOWLEDGED AND AGREED
TO THIS _____ DAY OF DECEMBER, 2012

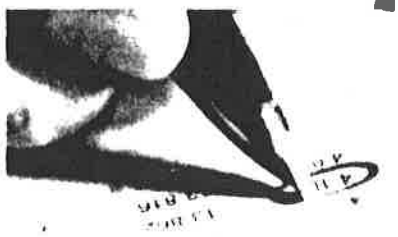
BAPTIST MEMORIAL REHABILITATION HOPITAL, G.P., a Delaware general partnership

By: Jason Little
Name: Jason Little
Title: Vice President

EXHIBIT A

Term Sheet

[see attached]



1. BUDGET AND LEASE TERM SHEET

TERM SHEET

PROJECT:	Development of a specialty hospital facility consisting of a two-story, approximately 53,500 square-foot structure consisting of 49 beds.
LANDLORD:	Duke Realty Development, LLC (to be formed)
TENANT(S):	Joint Venture of Baptist and Centerre ("Joint Venture")
DEVELOPER:	Duke Realty
ARCHITECT(S):	Duke Realty understands the project design will be completed by an architectural firm approved by the Joint Venture.
CONTRACTOR:	Duke Realty understands the project construction will be completed by a general contractor approved by the Joint Venture.

PRELIMINARY LEASE TERMS/RSF:

LEASE TERMS	JV
Rent Factor (Yield):	7.85%
Annual Net Rent Escalation:	2.25%
Total Development Budget:	$19,984,861
NNN Rent:	$29.32
Initial Lease Term:	15 years
FEES	
Development Fee:	3%

RENEWAL OPTIONS: Tenant shall be entitled to three 10-year lease renewals.

SCHEDULE: Total development time will not exceed eleven (11) months from the commencement of construction, pursuant to an executed space Lease. Immediately upon engagement, Duke Realty will update the detailed development schedule, including all milestones to be met by all parties, in order for the schedule to be maintained.

SPACE LEASE GUARANTOR: Both Baptist and Centerre as Joint Venture tenants will be responsible for their prorata share of the Lease. The Space Lease will provide a guaranty termination provision whereby prorata guaranties terminate if Tenant's EBITDAR exceeds two (2) times the monthly rent for the defined "Test Period" of previous four (4) consecutive quarters.

PURCHASE OPTION TERM: On the seventh (7th) anniversary of the substantial completion of the leased premises, the joint venture shall have the option to purchase the land and improvements (or assume the Ground Lease, if applicable) for a price equal to the greater of (i) either (A) the total initial cost of the land and improvements plus or inclusive of, as applicable, the unamortized cost of any capital expenditures and the unamortized cost of tenant improvements in tenant space or (B) in the event the improvements shall have been sold in the interim, the purchase price paid by the most recent purchaser plus the costs of any unamortized subsequent tenant improvements in tenant space or capital expenditures; (ii) the then-appraised value of the land and improvements (with such appraisals to assume continued occupancy by the Joint Venture under its lease for 100% of the space within the rehabilitation hospital under the same lease terms); and (iii) the sum of all capital contributions made by members of the owner of the land (or ground lessee, as the case may be) plus the outstanding balance of any leasehold mortgage, including any prepayment penalties or yield maintenance.

SITE CONTROL:	Duke Realty will enter into a purchase and sale agreement with Baptist and subsequently acquire from Baptist approximately six (6) acres of the thirteen (13) total acres on the proposed site (the "Property"). The Property must be adequately sized to provide parking for the Project per local code. A $3,000,000 line item has been included in the budget sheet to account for this fee simple land acquisition.
RENT COMMENCEMENT:	Rent Commencement shall occur thirty (30) days after substantial completion of the Leased Premises, which is currently anticipated to be approximately eleven (11) months from the date of commencement of construction.
NON-BINDING:	Nothing contained herein shall be binding on either party unless and until appropriate Lease documents are fully negotiated, executed, and exchanged by the parties. The terms set forth in this Term Sheet shall be effective so long as this Term Sheet is executed on or before March 31, 2013.

Balance Sheet and Income Statements

Economic Feasibility, 10

Centerre Healthcare Corporation

Consolidated Financial Statements
Years Ended December 31, 2011 and 2010

(With Independent Auditors' Report Thereon)

LATTIMORE BLACK MORGAN & CAIN, PC
CERTIFIED PUBLIC ACCOUNTANTS AND BUSINESS ADVISORS

Centerre Healthcare Corporation

Contents

LATTIMORE BLACK MORGAN & CAIN, PC
CERTIFIED PUBLIC ACCOUNTANTS AND BUSINESS ADVISORS

Independent Auditors' Report

To the Board of Directors and Shareholders of
Centerre Healthcare Corporation

We have audited the accompanying consolidated balance sheets of Centerre Healthcare Corporation and Subsidiaries (collectively, the "Corporation") as of December 31, 2011 and 2010 and the related consolidated statements of operations, shareholders' equity, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Corporation's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall consolidated financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centerre Healthcare Corporation and Subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Lattimore Black Morgan & Cain, P.C.

Brentwood, Tennessee
April 27, 2012

Centerre Healthcare Corporation

Consolidated Balance Sheets

December 31,	2011	2010
Assets		
Current assets		
Cash and cash equivalents	$ 18,284,073	$ 12,893,203
Accounts receivable, net of allowance for doubtful accounts of $894,772 and $647,720 in 2011 and 2010, respectively	7,532,975	6,028,487
Related party receivables	288,004	44,598
Inventories	376,414	325,901
Deferred income taxes	415,687	-
Prepaid expenses and other current assets	861,178	475,798
Total current assets	27,758,331	19,767,987
Property and equipment, net	5,095,538	3,526,373
Investments in joint ventures	5,638,873	5,720,124
Intangible assets	12,400,000	10,290,000
Deferred income taxes	10,871,461	-
Other assets	19,432	11,963
Total assets	$ 61,783,635	$ 39,316,447
Liabilities and Shareholders' Equity		
Current liabilities		
Accounts payable	$ 1,304,849	$ 1,081,712
Accrued expenses	3,890,896	2,825,009
Notes payable, current portion	806,287	356,025
Revolving lines of credit	5,294,330	5,375,000
Other current liabilities	440,824	432,395
Total current liabilities	11,737,186	10,070,141
Notes payable, excluding current portion	1,281,184	624,000
Deferred rent and other long-term liabilities	2,568,378	1,972,041
Total liabilities	15,586,748	12,666,182

See accompanying notes to consolidated financial statements.

Centerre Healthcare Corporation

Consolidated Balance Sheets, Continued

Shareholders' equity		
Series C redeemable convertible preferred stock: $0.001 par value; 23,034,850 and 15,177,300 shares authorized; 23,029,287 and 15,177,265 shares issued and outstanding in 2011 and 2010, respectively	**17,443,093**	**11,442,519**
Series B redeemable convertible preferred stock: $0.001 par value; 47,710,560 shares authorized; 38,348,991 shares issued and outstanding in 2011 and 2010, respectively	**29,109,638**	**29,047,377**
Series A/A-1 redeemable convertible preferred stock: $0.001 par value; 11,645,143 shares authorized; 10,434,373 shares issued and outstanding in 2011 and 2010, respectively	**8,814,724**	**8,812,390**
Common stock: $0.001 par value; 95,504,666 shares authorized; 3,932,755 and 3,826,505 shares issued and outstanding in 2011 and 2010, respectively	**3,933**	**3,827**
Stock warrants	**380,896**	**242,604**
Additional paid-in capital, common stock	**2,007,187**	**1,974,313**
Accumulated deficit	**(22,322,046)**	**(34,252,497)**
Centerre Healthcare Corporation shareholders' equity	**35,437,425**	**17,270,533**
Noncontrolling interests in subsidiaries	**10,759,462**	**9,379,732**
Total shareholders' equity	**46,196,887**	**26,650,265**
Total liabilities and shareholders' equity	**$ 61,783,635**	**$ 39,316,447**

See accompanying notes to consolidated financial statements.

Centerre Healthcare Corporation

Consolidated Statements of Operations

Year Ended December 31,	2011	2010
Revenue		
Net patient service revenue	$ 51,100,435	$ 42,221,214
Other revenue	2,491,285	1,666,612
Equity earnings from joint ventures	2,669,899	2,144,324
Total revenue	56,261,619	46,032,150
Operating expenses		
Salaries, wages and employee benefits	32,796,174	25,945,836
Rent expense	6,382,628	5,145,011
Other operating expenses	6,298,390	5,060,679
Supplies and drugs	3,033,804	2,771,871
Outside services	2,734,441	2,427,973
Provision for (recovery of) bad debts	294,670	(10,000)
Depreciation and amortization	1,061,039	926,724
Interest, net	358,177	327,615
Total expenses	52,959,323	42,595,709
Operating income before income taxes	3,302,296	3,436,441
Income tax benefit	11,216,119	-
Net income	14,518,415	3,436,441
Noncontrolling interests in net earnings of subsidiaries	(2,508,410)	(2,682,563)
Earnings from continuing operations	12,010,005	753,878
Income from discontinued operations	-	4,952
Net income attributable to Centerre Healthcare Corporation	$ 12,010,005	$ 758,830

See accompanying notes to consolidated financial statements.

	Preferred Stock C		Preferred Stock B		Preferred Stock A/A-1		Common Stock		Preferred Stock Warrants		Additional Paid-in Capital - Common Stock	Accumulated Deficit	Centerre Healthcare Corporation Shareholders' Equity	Noncontrolling Interests	Total Shareholders Equity
	Shares	Value	Shares	Value	Issued	Value	Shares	Par Value	Shares	Value					
Balance at December 31, 2009	15,177,285	$ 11,416,843	38,348,891	$ 28,914,865	16,434,373	$ 8,867,432	3,826,595	$ 3,827	2,249,237	$ 242,804	1,852,128	$ (34,847,881)	$ 16,466,838	$ 8,496,142	$ 24,964,981
Stock issuance costs	-	(420)	-	-	-	-	-	-	-	-	-	-	(420)	-	(420)
Accretion of stock issuance costs	-	26,298	-	132,472	-	4,958	-	-	-	-	-	(163,728)	-	-	-
Common stock-based compensation	-	-	-	-	-	-	-	-	-	-	22,184	-	22,184	-	22,184
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	-	121,500	121,500
Distributions to noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	-	(1,920,473)	(1,920,473)
Net income	-	-	-	-	-	-	-	-	-	-	-	758,830	758,830	2,682,563	3,441,393
Balance at December 31, 2010	15,177,285	11,442,519	38,348,891	29,047,377	16,434,373	8,812,390	3,826,595	3,827	2,249,237	242,804	1,874,313	(34,252,487)	17,270,533	9,379,732	26,650,265
Issuance of stock	7,852,022	5,995,804	-	-	-	-	106,250	106	-	-	4,144	-	6,000,054	-	6,000,054
Issuance of warrants	-	-	-	-	-	-	-	-	157,150	138,292	-	-	138,292	-	138,292
Stock issuance costs	-	(10,189)	-	-	-	-	-	-	-	-	-	-	(10,189)	-	(10,189)
Accretion of stock issuance costs	-	14,956	-	82,261	-	2,334	-	-	-	-	-	(79,554)	-	-	-
Common stock-based compensation	-	-	-	-	-	-	-	-	-	-	28,730	-	28,730	-	28,730
Contributions from noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	-	2,447,592	2,447,592
Distributions to noncontrolling interests	-	-	-	-	-	-	-	-	-	-	-	-	-	(3,576,272)	(3,576,272)
Net income	-	-	-	-	-	-	-	-	-	-	-	12,010,005	12,010,005	2,508,410	14,518,415
Balance at December 31, 2011	23,029,287	$ 17,443,090	38,348,891	$ 29,129,638	16,434,373	$ 8,814,724	3,832,795	$ 3,833	2,406,387	$ 381,096	$ 2,007,187	$ (22,322,946)	$ 35,437,425	$ 10,758,462	$ 46,195,887

See accompanying notes to consolidated financial statements.

Centerre Healthcare Corporation

Consolidated Statements of Cash Flows

Year Ended December 31,	2011	2010
Cash flows from operating activities		
Net income	$ 14,518,415	$ 3,436,441
Adjustments to reconcile operating income to net cash provided by operating activities:		
Equity earnings from joint ventures	(2,669,899)	(2,144,324)
Deferred income tax benefit	(11,287,148)	-
Depreciation and amortization	1,061,039	926,724
Common stock-based compensation	28,730	22,184
Amortization of line of credit discount	57,622	-
Provision for (recovery of) bad debts	294,670	(10,000)
Deferred rent	596,337	499,551
(Increase) decrease in operating assets:		
Accounts receivable	(1,799,158)	147,619
Related party receivables	(243,406)	133,079
Inventories	(50,513)	(86,430)
Prepaid expenses and other current assets	(385,380)	73,303
Other assets	(7,469)	4,200
Increase (decrease) in operating liabilities:		
Accounts payable	223,137	(287,377)
Accrued expenses	1,065,887	83,459
Other current liabilities	8,429	366,478
Net cash provided by continuing activities	1,411,293	3,164,907
Net cash provided by discontinued operations	-	4,952
Net cash provided by operating activities	1,411,293	3,169,859
Cash flows from investing activities		
Purchases of property and equipment	(2,630,204)	(853,361)
Investments in joint ventures	-	(611,840)
Distributions from investments in joint ventures	2,751,150	2,284,660
Net cash provided by investing activities	120,946	819,459
Cash flows from financing activities		
Proceeds from revolving lines of credit, net	-	931,130
Proceeds from notes payable	1,660,411	377,787
Payments on notes payable	(552,965)	(1,123,421)
Proceeds from issuance of stock	6,000,054	-
Stock issuance costs	(10,189)	(420)
Contributions from noncontrolling interests in subsidiaries	337,592	121,500
Distributions to noncontrolling interests in subsidiaries	(3,576,272)	(1,920,473)
Net cash provided by (used in) financing activities	3,858,631	(1,613,897)
Net increase in cash and cash equivalents	5,390,870	2,375,421
Cash and cash equivalents at beginning of year	12,893,203	10,517,782
Cash and cash equivalents at end of year	$ 18,284,073	$ 12,893,203
Supplemental schedule of noncash investing and financing activities:		
Capital lease agreement	$ -	$ 246,213
Conversion of line of credit to note payable	$ -	$ 614,908
Contribution of intangible asset	$ 2,110,000	$ -
Issuance of detachable stock warrants	$ 138,292	$ -
Supplemental cash flow information:		
Cash paid for interest, net	$ 322,138	$ 334,234

See accompanying notes to consolidated financial statements.

1. Corporation ownership and nature of business

Centerre Healthcare Corporation (the "Corporation") is a national company dedicated to developing and operating rehabilitation hospitals in partnership with leading acute hospitals. The Corporation was incorporated in the state of Delaware in 1999.

The Corporation has a partnership interest in and provides certain management services for five rehabilitation hospitals: Lancaster Rehabilitation Hospital, Mercy Rehabilitation Hospital – St Louis, Methodist Rehabilitation Hospital, The Rehabilitation Hospital of Wisconsin and Texas Rehabilitation Hospital of Fort Worth (collectively the "Hospitals"). Lancaster Rehabilitation Hospital and Mercy Rehabilitation Hospital – St. Louis opened in 2007. Methodist Rehabilitation Hospital and The Rehabilitation Hospital of Wisconsin opened in 2008. Texas Rehabilitation Hospital of Fort Worth opened in 2011. Additionally, the Corporation plans to open four additional hospitals during 2012 and 2013. Mercy Rehabilitation Hospital – Oklahoma City and Beachwood Rehabilitation Hospital are planned to open in 2012, and St. Mary's Rehabilitation Hospital and Community Health Network Rehabilitation Hospital are planned to open in 2013.

2. Summary of significant accounting policies

The significant accounting policies followed by the Corporation are described below and are in conformity with accounting principles generally accepted in the United States of America.

Fair value measurements – Fair value is a market-based measurement, not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, fair value accounting standards establish a fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity including quoted market prices in active markets for identical assets (Level 1), or significant other observable inputs (Level 2) and the reporting entity's own assumptions about market participant assumptions (Level 3). The Corporation does not have any fair value measurements using significant unobservable inputs (Level 3) as of December 31, 2011 or 2010.

Use of estimates - The preparation of consolidated financial statements in conformity with generally accepted accounting principles ("GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Principles of consolidation - The consolidated financial statements include the accounts of subsidiaries in which ownership is greater than 50% of the voting interest. Investments in entities in which the ownership percentage is between 20 - 50% of the voting interests are accounted for using the equity method, which records as income (loss) an ownership percentage of the reported income (loss) of the entity. All significant intercompany accounts and transactions have been eliminated in consolidation.

The Corporation owns a 50.50% interest in Mercy Rehabilitation Hospital - St. Louis, LLC, formerly St. John's Mercy Rehabilitation Hospital, LLC, ("St. John's") which provides rehabilitation services in St. Louis, Missouri. The investment is accounted for by consolidation. The remaining 49.50%, which is considered to be the noncontrolling interest, is owned by Mercy Hospital – St Louis, formerly St. John's Mercy Health System ("MHSL").

The Corporation owns a 51.00% interest in the Rehabilitation Hospital of Wisconsin, LLC ("RHOW") which provides rehabilitation services in Waukesha, Wisconsin. The investment is accounted for by consolidation. The remaining 49.00%, which is considered to be the noncontrolling interest, is owned by Waukesha Memorial Hospital, Inc ("WMH").

The Corporation owns a 70.00% interest in Texas Rehabilitation Hospital of Fort Worth, LLC ("TRHFW"), which provides rehabilitation services in Fort Worth, Texas. The investment is accounted for by consolidation. The remaining 30.00%, which is considered to be the noncontrolling interest, is owned by Texas Health Harris Methodist Fort Worth ("THHFW").

The Corporation owns a 50.50% interest in Mercy Rehabilitation Hospital ("MRH"), which will provide rehabilitation services in Oklahoma City, OK. The investment is accounted for by consolidation. The remaining 49.50%, which is considered to be the noncontrolling interest, is owned by Mercy Health Center ("MHC").

The Corporation owns a 55.00% interest in Beachwood Rehabilitation Hospital, LLC ("Beachwood"), which will provide rehabilitation services in Cleveland, OH. The investment is accounted for by consolidation. The remaining 45.00%, which is considered to be the noncontrolling interest, is owned by University Hospitals Health System ("UHHS").

The Corporation owns a 50.00% interest in Lancaster Rehabilitation Hospital, LLP ("Lancaster"), which provides rehabilitation services in Lancaster, Pennsylvania. The investment is accounted for under the equity method. The remaining 50.00% is owned by Lancaster General Hospital ("LGH").

The Corporation owns a 31.00% interest in MHS-CHC I, LP ("Methodist"), which provides rehabilitation services in Dallas, Texas. The investment is accounted for under the equity method. The remaining 69.00% is owned by Methodist Health System ("MHS").

The Corporation owns a 41.00% interest in St. Mary Rehabilitation Hospital ("SMRH"), which will provide rehabilitation services in Langhorne, PA. The investment is accounted for under the equity method. The remaining 59.00% is owned by St. Mary Medical Center ("SMMC").

The Corporation owns a 49.00% interest in Community Health Network Rehabilitation Hospital ("CRH"), which will provide rehabilitation services in Indianapolis, IN. The investment is accounted for under the equity method. The remaining 51.00% is owned by Community Health Network, Inc. ("CHN").

Cash and cash equivalents - The Corporation considers all highly-liquid investments with a maturity upon acquisition of three months or less to be cash equivalents.

Allowance for doubtful accounts - Accounts receivable primarily consist of amounts due from third-party payors and patients. The Hospitals' ability to collect outstanding receivables is critical to the Corporation's results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, the Hospitals establish an allowance for doubtful accounts to reduce the carrying value of such receivables to their estimated net realizable value. The primary uncertainty of such allowances lies with uninsured patient receivables and deductibles, co-payments or other amounts due from individual patients.

The Hospitals have an established process to determine the adequacy of the allowance for doubtful accounts that relies on a number of analytical tools and benchmarks to arrive at a reasonable allowance. No single statistic or measurement determines the adequacy of the allowance for doubtful accounts. Some of the analytical tools that the Hospitals utilize include, but are not limited to, historical cash collection experience, revenue trends by payor classification and revenue days in accounts receivable. Individual patient accounts receivable are written off after collection efforts have been followed in accordance with the Hospitals' policies.

Cost report settlements - Revenue under third-party payor agreements is subject to audit and retroactive adjustment. Provisions for estimated third-party payor settlements are provided in the period the related services are rendered. Differences between the estimated amounts accrued and interim and final settlements are reported in operations in the year of settlement. Adjustments relating to tentative or final settlements to estimated reimbursement amounts resulted in an increase in net patient service revenue of $202,526 and $149,491 for the years ended December 31, 2011 and 2010. Cost report settlement balances are included in other current liabilities in the accompanying consolidated financial statements.

Inventories - Inventories are stated at the lower of cost (first-in, first-out) or market and are comprised of purchased items. These inventory items are primarily operating supplies used in the direct or indirect treatment of patients.

Property and equipment - Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of equipment which range from 3 to 12 years. Leasehold improvements are amortized over the shorter of the estimated useful life or the respective lease term.

Expenditures for repairs, maintenance and minor renewals are charged to income as incurred. Expenditures, including the cost of parts and internal labor, which improve an asset or extend its estimated useful life, are capitalized. When equipment is retired or otherwise disposed of, the related cost and accumulated depreciation or amortization are removed from the accounts and any gain or loss is included in operations.

The carrying value of property and equipment is assessed for recoverability by management based on analysis of future undiscounted cash flows expected to result from the use and expected disposition of the asset. An impairment loss is recognized in income if the carrying amount of the asset is not recoverable and exceeds its fair value. Management believes there has been no impairment at December 31, 2011 or 2010.

Intangible assets - Intangible assets with indefinite lives are not amortized but reviewed for impairment annually or more frequently if certain indicators arise. Management believes there is no impairment at December 31, 2011 or 2010.

Warrants – Warrants associated with a line of credit are recorded as a discount, at fair value. The discount is amortized over the life of the loan, which approximates the effective interest method. The amortization is included in interest expense in the consolidated financial statements.

Deferred rent – Certain of the Hospitals' facility leases provide for escalating rent payments over the life of the lease. Generally accepted accounting principles require that the rent expense be recognized on a straight-line basis over the life of the lease. This accounting results in a non-interest bearing liability that increases during the early portion of the lease term, as the cash paid is less than the expense recognized, and reverses by the end of the lease term.

Net patient revenue - The Hospitals recognize revenues in the period in which services are performed. Accounts receivable primarily consist of amounts due from third-party payors and patients. Amounts the Hospitals receive for treatment of patients covered by governmental programs such as Medicare and Medicaid and other third-party payors such as health maintenance organizations, preferred provider organizations and other private insurers are generally less than the Hospitals' established billing rates. Accordingly, the revenues and accounts receivable reported in the consolidated financial statements are recorded at the net amount expected to be received.

The Hospitals derive a significant portion of their revenues from Medicare, Medicaid and other payors that receive discounts from their established billing rates. The Hospitals estimate the total amount of these discounts to prepare their financial statements. The Medicare and Medicaid regulations and various managed care contracts under which these discounts must be calculated are complex and are subject to interpretation and adjustment. The Hospitals estimate the allowance for contractual discounts on a patient-specific basis given their interpretation of the applicable regulations or contract terms. These interpretations sometimes result in payments that differ from the Hospitals' estimates. Additionally, updated regulations and contract renegotiations occur frequently, necessitating regular review and assessment of the estimation process by management. Changes in estimates related to the allowance for contractual discounts affect revenues reported in the consolidated statements of operations.

Self-pay revenues are derived primarily from patients who do not have any form of healthcare coverage. The revenues associated with self-pay patients are generally reported at the Hospitals' gross charges. The Hospitals evaluate these patients, after the patient's medical condition is determined to be stable, for their ability to pay based upon federal and state poverty guidelines, qualifications for Medicaid or other governmental assistance programs, as well as the Hospitals' policy for charity/indigent care.

Charity care - The Hospitals provide care without charge to certain patients who qualify under their charity care policies. For the years ended December 31, 2011 and 2010, the Hospitals provided direct and indirect costs of $291,824 and $110,915 in charity care, respectively. The Hospitals do not report a charity care patient's charges in revenues or in the provision for doubtful accounts, as it is the Hospitals' policy not to pursue collection of amounts related to services provided to these patients.

Noncontrolling interests - Consolidated net earnings (loss) is reduced by the proportionate amount of earnings (loss) associated with noncontrolling interests. Noncontrolling interests represent the equity interest of third-parties in consolidated entities which are not wholly-owned.

Income taxes - The Corporation accounts for taxes under the liability method, whereby deferred tax assets and liabilities are determined based on the difference between the financial statement and tax bases of assets and liabilities using enacted tax rates in effect for the year in which the differences are expected to affect taxable income.

Under generally accepted accounting principles, a tax position is recognized as a benefit only if it is "more likely than not" that the tax position would be sustained in a tax examination, with a tax examination being presumed to occur. The amount recognized is the largest amount of tax benefit that is greater than 50% likely of being realized on examination. For tax positions not meeting the "more likely than not" test, no tax benefit is recorded. The Corporation has no material uncertain tax positions that qualify for either recognition or disclosure in the consolidated financial statements.

As of December 31, 2011 and 2010, the Corporation has accrued no interest and no penalties related to uncertain tax positions. It is the Corporation's policy to recognize interest and/or penalties related to income tax matters in income tax expense.

The Corporation files U.S. Federal income tax returns and state returns under the states of Arizona, California, Delaware, Georgia, Missouri, Oklahoma, Pennsylvania, Tennessee, Texas and Wisconsin. The Corporation is currently open to audit under the statute of limitations for years ended December 31, 2008 through 2011.

Stock-based compensation - The Corporation accounts for stock-based compensation using the share-based payments method. Accordingly, stock-based compensation cost is measured at the grant date based on the value of the award and is recognized over the service period, which is usually the vesting period.

Discontinued operations - The Corporation ceased operations in two of its wholly-owned rehabilitation hospitals in 2007. The income and expenses related to the closed hospitals are accounted for as discontinued operations.

Adoption of new accounting pronouncements – In September 2011, the Financial Accounting Standards Board ("FASB") issued accounting standards relating to goodwill and other intangibles. This guidance allows an entity the option to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative impairment test prescribed by current accounting

standards. Under that option, an entity would no longer be required to calculate the fair value of a reporting unit unless the entity determines, based on the qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. An entity can bypass the qualitative assessment for any reporting unit in any period and proceed directly to the quantitative impairment test, and then resume performing the qualitative assessment in any subsequent period. These standards are effective for annual and interim impairment tests performed for fiscal years beginning after December 15, 2011 and early adoption is permitted. The Corporation elected to adopt the new guidance during 2011.

In August 2010, accounting standards relating to the presentation of insurance claims and related insurance recoveries for health care entities were amended to require the entity to recognize an insurance receivable at the same time that it recognizes the liability, measured on the same basis of the liability. These amendments are effective for financial statements for fiscal years beginning after December 15, 2010. Therefore the Corporation adopted these standards at the beginning of 2011.

In August 2010, accounting standards relating to the disclosure of charity care for health care entities were amended to require the entity to measure charity care based on the direct and indirect costs of providing the charity care. These amendments are effective for financial statements for fiscal years beginning after December 15, 2010. Therefore the Corporation adopted these standards at the beginning of 2011.

The impact of adopting these accounting standards was not material to the consolidated financial statements.

New accounting pronouncements – In July 2011, the FASB issued accounting standards that require changes in financial statement presentation and enhanced disclosures by health care entities that recognize significant amounts of patient service revenue at the time services are rendered without taking account of patients' ability to pay. These standards require health care entities to change the presentation of their statement of operations by

reclassifying the provision for bad debts associated with patient service revenue from an operating expense to a deduction from patient service revenue (net of contractual allowances and discounts). Additionally, these entities will be required to provide enhanced disclosure about their policies for recognizing revenue and assessing bad debts as well as qualitative and quantitative information about changes in the allowance for doubtful accounts. These standards are effective for fiscal years ending after December 15, 2012, and therefore the Corporation expects to adopt these standards at the beginning of 2012. The Corporation is currently assessing the impact of adopting these accounting standards.

Events occurring after the reporting date – The Corporation has evaluated events and transactions that occurred between December 31, 2011 and April 27, 2012, which is the date the consolidated financial statements were available to be issued, for possible recognition or disclosure in the consolidated financial statements. See Note 15 for disclosure of subsequent events occurring after December 31, 2011.

3. Credit risk and other concentration

The Corporation and the Hospitals maintain cash and cash equivalents on deposit at banks in excess of federally insured amounts. The Corporation and the Hospitals have not experienced any losses in such accounts and management believes the Corporation and Hospitals are not exposed to any significant credit risk related to cash and cash equivalents.

Beginning December 31, 2010, through December 31, 2012, all noninterest-bearing transaction accounts are fully insured, regardless of the balance of the account, at all FDIC-insured institutions. The unlimited insurance coverage is available to all depositors, including consumers, businesses, and government entities. This unlimited insurance coverage is separate from, and in addition to, the insurance coverage provided to a depositor's other deposit accounts held at an FDIC-insured institution.

During 2011 and 2010, approximately 64% and 62% of the Hospitals' revenues related to patients participating in Medicare and Medicaid programs, respectively. Accounts receivable from

Medicare and Medicaid accounted for approximately 58% and 53% of accounts receivable as of December 31, 2011 and 2010, respectively. The Corporation's management recognizes that revenues and receivables from government agencies are significant to the Hospitals' operations, but it does not believe that there are significant credit risks associated with these governmental agencies. The Corporation's management does not believe that there are any other significant concentrations of revenues from any particular payor that would subject the Hospitals to any significant credit risks in the collection of their accounts receivable.

4. Property and equipment

Property and equipment consists of the following at December 31, 2011 and 2010:

	2011	2010
Leasehold improvements	$ 1,558,710	$ 1,537,723
Hospital equipment	4,728,988	3,555,505
Data processing equipment	2,446,153	1,817,229
Construction in process	338,230	-
	9,072,081	6,910,457
Less accumulated depreciation and amortization	(3,976,543)	(3,384,084)
	$ 5,095,538	$ 3,526,373

The construction in progress balance as of December 31, 2011 represents costs in connection with the construction of a 22-bed stroke unit at St. John's, which is scheduled to open on July 1, 2012. Estimated costs to complete this unit amount to approximately $3,600,000.

5. Investments in joint ventures

Condensed financial data for each investment in joint venture for 2011 is as follows (amounts in thousands):

	Lancaster (audited)	Methodist (audited)
Condensed statements of operations		
Net patient and other revenue	$ 20,955	$ 17,080
Total operating expenses	16,895	14,760
Net income	4,060	2,320
Condensed balance sheets		
Current assets	6,143	3,969
Non-current assets	3,958	737
Total assets	$ 10,101	$ 4,706
Current liabilities	$ 2,847	$ 908
Non-current liabilities	735	483
Partners' capital	6,519	3,315
Total liabilities and partners' capital	$ 10,101	$ 4,706

Condensed financial data for each investment in joint venture for 2010 is as follows (amounts in thousands):

	Lancaster (audited)	Methodist (audited)
Condensed statements of operations		
Net patient and other revenue	$ 19,047	$ 15,947
Total operating expenses	15,745	14,273
Net income	3,302	1,674
Condensed balance sheets		
Current assets	5,385	3,596
Non-current assets	4,114	847
Total assets	$ 9,499	$ 4,443

Current liabilities	$ 2,158	$ 746
Non-current liabilities	812	392
Partners' capital	6,529	3,305
Total liabilities and partners' capital	$ 9,499	$ 4,443

The Corporation is in development and construction of SMRH and CRH. These entities are consolidated as investment in joint ventures, and had net losses of $183,625 and $8,125, respectively. The equity accounts of SMRH and CRH have accumulated losses of $213,685 and $8,125, respectively.

6. Intangible assets

In conjunction with the initial capitalization of St. John's, MHSL contributed a separately identifiable intangible asset for its previously existent rehabilitation line of business that was operated within MHSL. The value assigned to the line of business is estimated to have an indeterminate useful economic life and is evaluated for impairment annually. This contribution did not include any significant tangible assets or liabilities. This contribution was valued, by an independent agency, to be worth $7,850,000. This amount was used as MHSL's contribution to St. John's and was recorded as a separately identifiable intangible asset.

In conjunction with the initial capitalization of RHOW, WMH contributed a separately identifiable intangible asset for its previously existent rehabilitation line of business that was operated within WMH. The value assigned to the line of business is estimated to have an indeterminate useful economic life and is evaluated for impairment annually. The contribution did not include any significant tangible assets or liabilities. The contribution was valued, by an independent agency, to be worth $2,440,000. This amount was used as WMH's contribution to RHOW and was recorded as a separately identifiable intangible asset.

In conjunction with the initial capitalization of TRHFW during 2011, THHFW contributed a separately identifiable intangible asset for its previously existent rehabilitation line of business that was operated within THHFW. The value assigned to the line of

business is estimated to have an indeterminate useful economic life and is evaluated for impairment annually. The contribution did not include any significant tangible assets or liabilities. The contribution was valued, by an independent agency, to be worth $2,110,000. This amount was used as THHFW's contribution to TRHFW and was recorded as a separately identifiable intangible asset.

7. Debt

Lines of credit consist of the following at December 31, 2011 and 2010:

	2011	2010
Line of credit with Square One Bank with an availability of $8,000,000, with interest payable monthly at a variable rate (5% at December 31, 2011) with principal balance due at maturity in June 2012, secured by the assets of the Corporation.	$ 4,000,000	$ 4,000,000
Line of credit with UMB Bank with an availability of $2,500,000, with interest payable monthly at an index rate determined by the lender (2.75% at December 31, 2011) with principal balance due at maturity in June 2012, secured by the assets of St. John's.	1,375,000	1,375,000
	5,375,000	5,375,000
Line of credit discount	(80,670)	-
	$ 5,294,330	$ 5,375,000

In connection with the extension of the Square One Bank line of credit in 2011, the Corporation issued detachable stock warrants (the "Warrants") that are exercisable into 157,150 shares of the Company's Series C convertible preferred stock. The warrants are reflected in the consolidated financial statements as a discount on the line of credit and an increase in stock warrants. The discount is being amortized using a method that approximates the effective interest method over the term of the line of credit. The fair value of the warrants on the date of issuance was $138,292.

The warrants are exercisable at $0.76 per share. The number of warrants and the price per exercisable share are subject to certain adjustments as provided in the warrant agreement. The warrants expire on July 22, 2018.

Management is currently in negotiations to restructure or extend the $8,000,000 line of credit and anticipates the transaction will be completed prior to the date of maturity.

Management is currently in negotiations with UMB Bank to extend the $2,500,000 line of credit and anticipates the extension will be completed prior to the date of maturity.

Notes payable consist of the following at December 31, 2011 and 2010:

	2011	2010
Note payable to WMH with interest payable at a fixed rate of 5%. The note was unsecured and repaid in June 2011.	$ -	$ 186,751
Capital lease obligation with monthly payments of $3,399, which includes principal and interest based on a fixed rate of 9.88%, with final installment due in March 2016.	141,081	-

Capital lease obligation with monthly payments of $5,941, which includes principal and interest based on a fixed rate of 7.4%, with final installment due in November 2014.	208,918	241,790
Note payable due in monthly installments of $12,000 with interest payable at a fixed rate of 6%, with final installment due in May 2015.	437,472	551,484
Note payable due in monthly installments of $50,000, which includes principal and interest based on a fixed rate of 5.0%. The balance is amortized over a period of 30 months with final installment due in February 2014.	1,300,000	-
	2,087,471	980,025
Less short-term balance	(806,287)	(356,025)
Long-term balance	$ 1,281,184	$ 624,000

The Corporation's credit facilities have certain financial covenant requirements of which the Corporation was in compliance at December 31, 2011 and 2010.

Future maturities of debt at December 31, 2011 are as follows:

Year Ending December 31,	
2012	$ 6,181,287
2013	821,231
2014	337,307
2015	112,615
2016	10,031
Total	$ 7,462,471

8. Preferred stock

Series A and Series A-1 preferred stock were issued in September 2002 when the Corporation was initially funded. Subsequent to the issuance of the Series A and Series A-1 preferred stock the investors entered into a note and warrant purchase agreement dated August 15, 2003 whereby the Series A and A-1 investors loaned certain monies to the Corporation in exchange for promissory notes and warrants. The warrants expire in August 2013.

In June 2005, the Corporation issued its Series B preferred stock to existing and new investors. As part of that transaction, the promissory notes dated December 30, 2004 were converted (principal and interest) into shares of Series B preferred stock.

Series C preferred stock was issued to existing investors for approximately $11,500,000 and $6,000,000 in October 2008 and January 2011, respectively, as part of a qualified equity financing in accordance with the bridge loan agreement. A "Qualified Equity Financing" is defined as the first sale of preferred stock of the Corporation following the date of the note purchase agreement that results in cash proceeds to the Corporation (excluding the conversion of the bridge loans) of at least $5 million. The outstanding principal and accrued interest amounting to $6,589,361 under the bridge loans was converted into Series C preferred stock.

BVP Affiliates Fund Limited and Baird Venture Partners Limited (collectively, "Baird"), invested in Series A, A-1, and B preferred stock. Baird did not invest in the Series C preferred stock and as a result of the provisions of the Series C stock purchase agreement the previous classes of preferred stock held by Baird were converted to common stock during 2008 on a one-for-one basis.

In 2007, warrants were issued to holders pursuant to the Corporation's bridge loans and warrant purchase agreements. Each lender was issued warrants amounting to 20% of the principal amount of the bridge loan issued to such lender. Each warrant shall be exercisable for that number of shares of common stock at an exercise price of $.01. The warrants expire in July 2017.

Voting
Each holder of preferred stock has voting rights equal to an equivalent number of shares of common into which it is convertible.

Conversion
Each share of preferred stock may at the option of the shareholder be converted at any time into shares of common stock by dividing the original issue price by the conversion price, as defined, subject to adjustments under specific circumstances. Each share of preferred stock automatically coverts into the number of shares of common stock into which such shares are convertible immediately upon the earlier of: 1) the closing of an initial public offering which results in gross cash proceeds to the Corporation of $30,000,000 or 2) 60% of the consent of the holders of preferred stock. The preferred stock is redeemable at the option of the holder upon written notice to the Corporation of the intent to convert previously held preferred shares into common shares.

Redemption
At any time after October 10, 2014, the holders of not less than sixty percent (60%) of the then outstanding shares of Series A/A-1 preferred stock, Series B preferred stock and Series C preferred stock, voting together as a single class, on an as-converted basis (the "Preferred 60% Majority"), may elect to have the Corporation

redeem their Series A/A-1 preferred stock, Series B preferred stock and Series C preferred stock at the preferred stock redemption price (defined below) by delivering written notice of such election (the "Redemption Election") to the Corporation.

The "Preferred Stock Redemption Price" payable with respect to each share of preferred stock shall be equal to the greater of (i) the fair market value (determined without any discount for minority interest, restrictions on transfer, lack of marketability or similar factors) of such share of Series A/A-1 preferred stock, Series B preferred stock, and Series C preferred stock on the date the Redemption Election is received by this Corporation, or (ii) the Original Series A/A-1 Issue Price in the case of the Series A/A-1 preferred stock, the Original Series B Issue Price in the case of the Series B preferred stock, and the Original Series C Issue Price in the case of the Series C preferred stock (as adjusted for any stock splits, stock dividends, recapitalizations or the like), in each case plus all declared but unpaid dividends on each share of preferred stock after the date hereof to be redeemed. The Corporation is recording accretion of stock issuance costs through October 2014 based on the original issue prices.

Dividends

Holders of Series C preferred stock shall be entitled to receive noncumulative dividends at the per annum rate of 8%, out of any assets legally available thereof, prior to and in preference to any declaration or payment of any dividend of the Series A preferred stock, Series A-1 preferred stock, Series B preferred stock, or common stock of the Corporation.

Holders of Series A, A-1, and B preferred stock shall be entitled to receive noncumulative dividends at the per annum rate of 8%, out of any assets legally available thereof, prior to and in preference to any declaration or payment of any dividend on the common stock of the Corporation.

Only declared but unpaid dividends, of which there are none as of December 31, 2011 or 2010, are reflected within the consolidated financial statements.

The holders of preferred stock are also entitled to participate in dividends on common stock on an as-if converted basis.

Liquidation Preference
In the event of any dissolution, liquidation or winding up of the affairs of the Corporation, the holders of Series C preferred stock shall be entitled to receive, prior and in preference to any distribution of any of the assets of the Corporation to all other holders of the Corporation's securities, an amount per share equal to the sum of the original issue price plus all declared but unpaid dividends on those shares.

After the payment in full to the holders of the Series C preferred stock, the holders of Series A, A-1, and B preferred stock shall be entitled to receive, prior to an in preference to any distribution of any of the assets of the Corporation to all other holders of the Corporation's securities other than to the holders of Series C preferred stock, an amount per share equal to the sum of the original issue price plus all declared but unpaid dividends on those shares.

After payment of the liquidation preference, any remaining assets of the Corporation are distributed pro-rata amount the holders of the preferred stock and holders of the common stock. If upon the occurrence of such event, the assets and funds distributed among the preferred stock holders is insufficient to permit the payment to such holders of the full preferential amount, the entire assets and funds of this Corporation legally available for distribution shall be distributed ratably among the holders of the preferred stock in proportion to the full proportional amount that each such holder is otherwise entitled to receive.

After payment has been made to the preferred stock shareholders, the remaining assets legally available for distribution shall be distributed among the holders of the preferred stock on an as-converted basis and common stock pro rata based on the number of shares of common stock held by each.

9. Common stock

The Corporation's certificate of incorporation as amended authorizes the Corporation to issue 95,504,666 shares of $.001 par value common stock.

Each share of common stock is entitled to one vote. The holders of common stock are also entitled to receive dividends whenever funds are legally available, as and when declared by the Board of Directors, subject to the prior rights of holders of all classes of stock outstanding.

10. Stock option plan

In 2002, the Corporation adopted the 2002 Stock Option Plan (the "Plan"). The Plan provides for the granting of stock options to employees, outside directors and consultants of the Corporation. Options granted under the Plan may be either incentive stock option or nonqualified stock options. Incentive stock options ("ISO") may be granted only to company employees (including officers and directors who are also employees). Non-qualified stock options ("NSO") may be granted to Corporation employees and outside directors and consultants. All stock options have four year terms and expire ten years from the date of grant. The Corporation has reserved shares of common stock for issuance under the Plan.

Stock option activity for the years ended December 31, 2011 and 2010 is summarized as follows:

	Shares	Option Price/Share	Weighted Average Price/Share
Outstanding at December 31, 2009	6,139,862	$ 0.04-0.10	$ 0.08
Granted	560,000	$ 0.08	$ 0.08
Forfeited	(430,000)	$ 0.08	$ 0.08
Outstanding at December 31, 2010	6,269,862	$ 0.04-0.10	$ 0.08
Granted	2,161,550	$ 0.16	$ 0.16
Exercised	(106,250)	$ 0.04	$ 0.04
Forfeited	(343,750)	$0.04- 0.08	$ 0.06
Outstanding at December 31, 2011	7,981,412	$ 0.04-0.16	$ 0.10

As of December 31, 2011, the weighted-average remaining contractual life of the outstanding options was approximately seven years. As of December 31, 2011, 4,751,973 options were exercisable under the Plan.

The fair value of each option award is estimated on the date of grant using a Black-Scholes option valuation model that uses the following assumptions: 1) expected volatility; 2) expected term (in years); and 3) risk free rate. Expected volatility is based on selected public healthcare companies. The expected term of options granted is based on the vesting period. The risk-free rate for each option is based on the U.S. Treasury yield curve in effect at the time of the grant. The fair value of the options granted during 2011 and 2010 was $0.16 and $0.08 per share, respectively. For the years ending December 31, 2011 and 2010 stock compensation expense amounted to $28,730 and $22,184, respectively.

11. Related party transactions

The Corporation provides certain management services to CRH, SMRH, Lancaster and Methodist. These Hospitals pay the Corporation a fixed monthly management fee and also reimburse the Corporation for direct general and administrative expenses. The Corporation also purchases healthcare benefits as well as incurs start-up costs related to equipment and services during each hospital's first year of operation. These additional expenditures are reimbursed to the Corporation at cost. Management fee revenue received from these Hospitals during 2011 and 2010 was $991,668 and $881,675 respectively.

The amount receivable from CRH as of December 31, 2011 amounted to $4,125. There were no receivables from CRH as of December 31, 2010.

The amount receivable from SMRH as of December 31, 2011 and 2010 amounted to $211,685 and $30,000, respectively.

The amount receivable from Lancaster as of December 31, 2011 and 2010 amounted to $48,334 and $7,399, respectively.

The amount receivable from Methodist as of December 31, 2011 and 2010 amounted to $23,860 and $7,199, respectively.

12. Commitments and contingencies

Legal - The Corporation and Hospitals are, from time to time, subject to various claims and legal actions arising in the normal course of business. In the opinion of management, any such claims and actions will be either adequately covered by insurance or will not have a material adverse effect on the Corporation's or Hospitals' financial position, results of operations or liquidity.

Payors - Laws and regulations governing Medicare, Medicaid, and other payor health care programs are complex and subject to interpretation. The Hospitals' management believes that the Hospitals are in compliance with all applicable laws and regulations in all material respects. Compliance with such laws and regulations is subject to future government review and interpretation as well as significant regulatory action including fines, penalties, and exclusion from the Medicare, Medicaid, and other payor health care programs.

The Centers for Medicare and Medicaid Services ("CMS") have implemented a Recovery Audit Contractors ("RAC") program. The purpose of the program is to reduce improper Medicare and Medicaid payments through the detection and recovery of overpayments. CMS has engaged subcontractors to perform these audits and they are being compensated on a contingency basis based on the amount of overpayments that are recovered. While management believes that all Medicare and Medicaid billings are proper and adequate support is maintained, certain aspects of Medicare and Medicaid billing, coding and support are subject to interpretation and may be viewed differently by the RAC auditors than by Hospital management. As the amount of recovery, if any, is unknown, management has not recorded any reserves related to a potential RAC audit at this time.

Healthcare Reform - In March 2010, Congress adopted comprehensive health care insurance legislation, the Patient Care Protection and Affordable Care Act ("collectively, the "Health Care Reform Legislation"). The Health Care Reform Legislation, among other matters, is designed to expand access to health care coverage to substantially all citizens through a combination of public program expansion and private industry health insurance. Provisions of the Health Care Reform Legislation become effective at various dates over the next several years and a number of additional steps are required to implement these requirements. Due to the complexity of the Health Care Reform Legislation, reconciliation and implementation of the legislation continues to be under consideration by lawmakers, and it is not certain as to what changes may be made in the future regarding health care policies. Changes to existing Medicaid coverage and payments

are also expected to occur as a result of this legislation. While the full impact of Health Care Reform Legislation is not yet fully known, changes to policies regarding reimbursement, universal health insurance and managed competition may materially impact the Hospitals' operations.

Leases - The Corporation's corporate offices, located in Brentwood, Tennessee, are leased from Park Center Partnership II. The lease expires on December 31, 2013. The lease contains a fixed escalation provision requiring monthly lease payments to increase by 2.5% annually. Corporate rent expense, on a straight-line basis, for 2011 and 2010 was $132,900 and $130,399, respectively. The related deferred rent of $13,112 and $8,125 as of December 31, 2011 and 2010, respectively, is included in long-term liabilities in the accompanying consolidated financial statements.

The approximate future minimum lease payments under the Corporation's operating lease are as follows:

Year Ending December 31,	Amount
2012	$ 131,000
2013	147,000
Total	$ 278,000

St. John's leases its facilities as part of a 20 year operating lease with G&E Healthcare REIT. The lease contains a fixed escalation provision requiring monthly lease payments to increase by 2% annually. Rent expense, on a straight-line basis, for 2011 and 2010 was $3,599,148, respectively. The related deferred rent of $2,393,188 and $1,963,916 as of December 31, 2011 and 2010, respectively, is included in long-term liabilities in the accompanying consolidated financial statements.

The approximate future minimum lease payments under St. John's operating leases are as follows:

Year Ending December 31,	Amount
2012	$ 4,139,000
2013	4,128,000
2014	4,125,000
2015	4,106,000
2016	4,079,000
Thereafter	43,511,000
Total	$64,088,000

RHOW leases its facilities as part of a 15 year operating lease with WMH. Monthly lease payments increase each year by a factor based on 70% of the Consumer Price Index. During the years ended December 31, 2011 and 2010, rent expense under this lease was $1,077,132 and $1,120,434, respectively.

The approximate future minimum lease payments under RHOW's operating leases are as follows:

Year Ending December 31,	Amount
2012	$ 1,175,000
2013	1,168,000
2014	1,155,000
2015	1,155,000
2016	1,155,000
Thereafter	7,696,000
Total	$13,504,000

TRHFW leases a building and grounds under 15 and 60 year operating leases, respectively. The ground lease contains a fixed escalation provision requiring monthly lease payments to increase by 2.5% annually. Rent expense, on a straight-line basis, for 2011 was $1,118,098. The related deferred rent of $28,745 at December

31, 2011 is included in long-term liabilities in the accompanying consolidated financial statements. The ground lease terminates automatically, without penalty, upon termination of the building lease. As such, the fixed escalation provision and future minimum lease payments for the ground lease are accounted for and disclosed over the same 15 year period as the building lease.

In connection with the building lease, TRHFW will receive approximately $150,000 from the landlord as a lease incentive to assist with tenant build-out expenditures. TRHFW is amortizing the incentive over the life of the related lease agreement as a reduction in rental expense. The lease incentive is included in other current assets and other long-term liabilities in the accompanying consolidated financial statements.

The approximate future minimum lease payments under TRHFW's operating leases are as follows:

Year Ending December 31,	Amount
2012	$ 1,637,000
2013	1,642,000
2014	1,648,000
2015	1,654,000
2016	1,660,000
Thereafter	15,811,000
Total	$24,052,000

13. Income Taxes

The income tax provision for the years ended December 31, 2011 and 2010 consists of:

	2011	2010
Current provision	$ 71,029	$ -
Deferred tax expense (benefit)	489,852	(323,000)
Change in valuation allowance	(11,777,000)	323,000
Total	$(11,216,119)	$ -

Net deferred income tax assets at December 31, 2011 are as follows:

	Current	Long-term
Deferred income tax assets	$ 415,687	$ 10,871,461
Deferred income tax liabilities	-	-
Less valuation allowance	-	-
Net deferred income tax assets	$ 415,687	$ 10,871,461

Net deferred income tax assets at December 31, 2010 are as follows:

	Current	Long-term
Deferred income tax assets	$ 313,000	$ 11,491,000
Deferred income tax liabilities	-	(27,000)
Less valuation allowance	(313,000)	(11,464,000)
Net deferred income tax assets	$ -	$ -

The deferred income tax assets result primarily from federal and state net operating loss carryforwards. At December 31, 2011, the Corporation had approximately $28,000,000 of net operating loss carryforwards available to offset future taxable income. The losses have a carryforward period of no more than 20 years and begin to expire in 2024 and may be subject to other limitations.

The Corporation has determined that based on historical positive operating factors and tax planning strategies available to the Corporation, net deferred tax assets at December 31, 2011 will be utilized to offset future taxes except for net operating loss carry-forward generated in the State of Arizona. The State of Arizona net operating loss carry-forward was written-off as of December 31, 2011. No valuation allowance is necessary as of December 31, 2011.

14. Discontinued Operations

During the fourth quarter of 2006, the Corporation ceased operations of its Westchester Rehabilitation Hospital and Phoenix Rehabilitation Hospital due to a change in the Corporation's business model regarding stand-alone hospitals.

In 2010, the Corporation generated income of $4,952 from discontinued operations upon collection of previously written-off accounts receivable. No income or loss from discontinued operations was generated in 2011.

15. Subsequent events

In February 2012, Square One Bank (the "Bank") issued a letter of credit for TRHFW, subject to the terms of a master letter of credit agreement, not to exceed $750,000. The letter of credit is secured by the balance(s) in any deposit account issued by the bank in TRHFW's name.

In 2012, the consolidated joint ventures declared and paid cash distributions of $3,063,478 to its members, of which the Corporation received $1,781,248.

In 2012, joint ventures in which the Corporation has equity interests declared and paid cash distributions of $4,426,691 to its members, of which the Corporation received $2,044,874.

In 2012, the Corporation made contributions of approximately $57,000 to consolidated joint ventures and $56,000 to joint ventures in which the Corporation has equity interests, respectively.

State Survey/Inspection

Orderly Development 7 (d)

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
761-B AIRWAYS BOULEVARD
JACKSON, TENNESSEE 38301-3203

February 13, 2008

Ms. Susan Stralka, Administrator
Baptist Rehab Germantown
2100 Exeter Road
Germantown, TN 38138

RE: Licensure Survey

Dear Ms. Stralka:

We are pleased to advise you that no deficiencies were cited as a result of the licensure survey completed at your facility on **February 6, 2008**. The attached form is for your files.

If this office may be of any assistance to you, please do not hesitate to call (731) 421-5113.

Sincerely,

Celia Skelley, MSN, RN
Public Health Nurse Consultant 2

CES/TJW

Enclosure

PRINTED: 02/13/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN#531105	A. BUILDING _____ B. WING _____	02/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST REHABILITATION GERMANTOWN	2169 EXETER ROAD GERMANTOWN, TN 38138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 002	1200-8-1 No Deficiencies This Rule is not met as evidenced by: This facility complies with all requirements for participation in the Hospital Facilities program reviewed during the annual licensure survey conducted on 2/6/08.	H 002		

Division of Health Care Facilities

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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STATE OF TENNESSEE
DEPARTMENT OF HEALTH
WEST TENNESSEE HEALTH CARE FACILITIES
781-B AIRWAYS BOULEVARD
JACKSON, TENNESSEE 38301-3203

February 25, 2008

Ms. Susan Stralka, Administrator
Baptist Rehab Germantown
2100 Exeter Road
Germantown, TN 38138

RE: Fire Safety Licensure Survey

Dear Ms. Stralka:

Enclosed is the statement of deficiencies for the fire safety licensure survey completed at your facility on February 21, 2008. Based upon 1200-8-1-.06, you are asked to submit an acceptable plan of correction for achieving compliance with completion dates, and signature 10 days from the date of this letter.

Please address each deficiency separately with positive and specific statements advising this office of a plan of correction that includes acceptable time schedule, which will lead to the correction of the cited deficiencies. Enter on the right side of the State Form, opposite the deficiencies, your planned action to correct the deficiencies and the expected completion date. The completion date can be no longer than 45 days from the day of survey. Before the plan can be considered "acceptable," it must be signed and dated by the administrator

Your plan of correction must contain the following:

- How the deficiency will be corrected;
- How the facility will prevent the same deficiency from recurring.
- The date the deficiency will be corrected;
- How ongoing compliance will be monitored.

Please be advised that under the disclosure of survey information provisions, the Statement of Deficiencies will be available to the public.

If assistance is needed, please feel free to call me at 731-421-5113.

Sincerely,

Celia Skelley/TW

Celia Skelley, MSN, RN
Public Health Consultant Nurse 2

CS/TW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP531105	A. BUILDING 01 - MAIN BUILDING 01 B. WING 2007 DEC 14 PM 3 08	02/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST REHABILITATION GERMANTOWN	2100 EXETER ROAD GERMANTOWN, TN 38138

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 871	1200-8-1-.08 (1) Building Standards (1) The hospital must be constructed, arranged, and maintained to ensure the safety of the patient. This Rule is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the corridor fire doors in a manner that would ensure the safety of the residents. The findings include: 2nd floor Observations during the facility tour on 2-21-08 beginning at 9:00 AM, the corridor fire door (A213B) at room 207 did not close and latch. 1st floor Observations during the facility tour on 2-21-08 beginning at 9:00 AM, the Bio-Hazard room door (139B) in Surgery did not close and latch.	H 871	The two doors which were not closing and latching properly have been repaired The facility's preventive maintenance plan includes the checking of doors for closing and latching. This is checked on a monthly basis. Ongoing compliance will be monitored by plant operations.	2-26-08

vision of Health Care Facilities

RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE CEO Administ (X6) DATE

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COPY-

SUPPLEMENTAL-1

Baptist Memorial Rehab. Hospital

CN1212-061

SUPPLEMENTAL RESPONSES

Baptist Memorial Rehabilitation Hospital, G.P.

December 2012

SUPPLEMENTAL

1. **Section A, Applicant Profile, Item 3**

   Please submit documentation from the Tennessee Secretary of State that acknowledges and verifies the type of ownership as identified by the applicant. Please also submit a corporate charter for the applicant facility. Please also provide a copy of the articles of organization.

Response

As described in the State of Delaware Statement of Partnership Existence in Exhibit Section A-3, the ownership type is a General Partnership. A corporate charter and articles of organization are not available. Public notice documentation has not been filed with the Tennessee Secretary of State. According to the Tennessee Secretary of State website, filing documentation in Tennessee for a general partnership is optional as shown below:

> *Filings by general partnerships are not for the purpose of forming or maintaining a general partnership in Tennessee. Document filing is for the purpose of providing public notice of basic information about a general partnership, such as the agency authority of its partners, and such filings are optional and voluntary.*

However, please refer to the Statement of Partnership Existence in Exhibit Section A-3 as proof that the partnership does exist.

2. Section A, Applicant Profile, Item 4

Please provide the ownership structure for Centerre Healthcare and Baptist Memorial Healthcare.

The Joint Venture Ownership Structure Chart is noted. Please clarify what the purchased services agreement entails between Baptist Memorial and Baptist Memorial Rehabilitation Hospital, GP. Also, what is the Community Advisory Board?

Please provide a brief narrative explaining the Joint Ownership Structure Chart.

Response

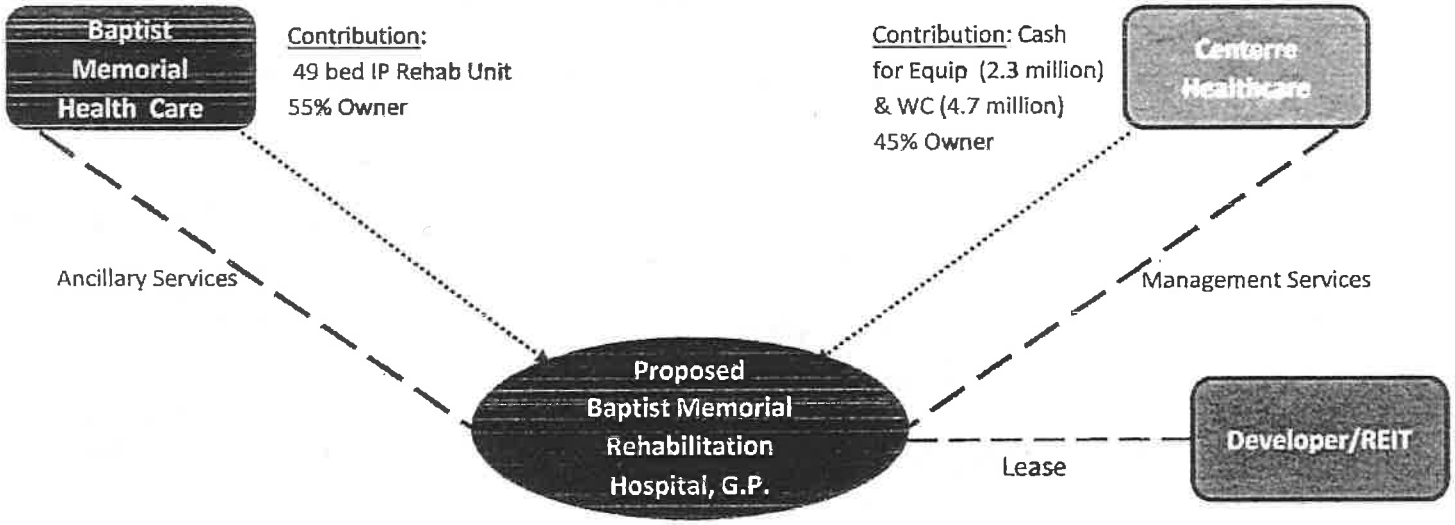
Centerre Healthcare Corporation is a national provider of inpatient acute rehabilitation services, dedicated to partnering with medical centers. The company was incorporated in 1999 and is based in Brentwood, Tennessee. The relationship with CRH of Memphis LLC is shown on the Chart on the following page.

Baptist Memorial Health Care Corporation is a system including 14 hospitals and an array of home care and hospice agencies, minor medical clinics, behavioral health programs and a network of surgery, rehabilitation and other outpatient centers. The relationship with Baptist Memorial Health Services Inc. is shown on the Chart on the following page.

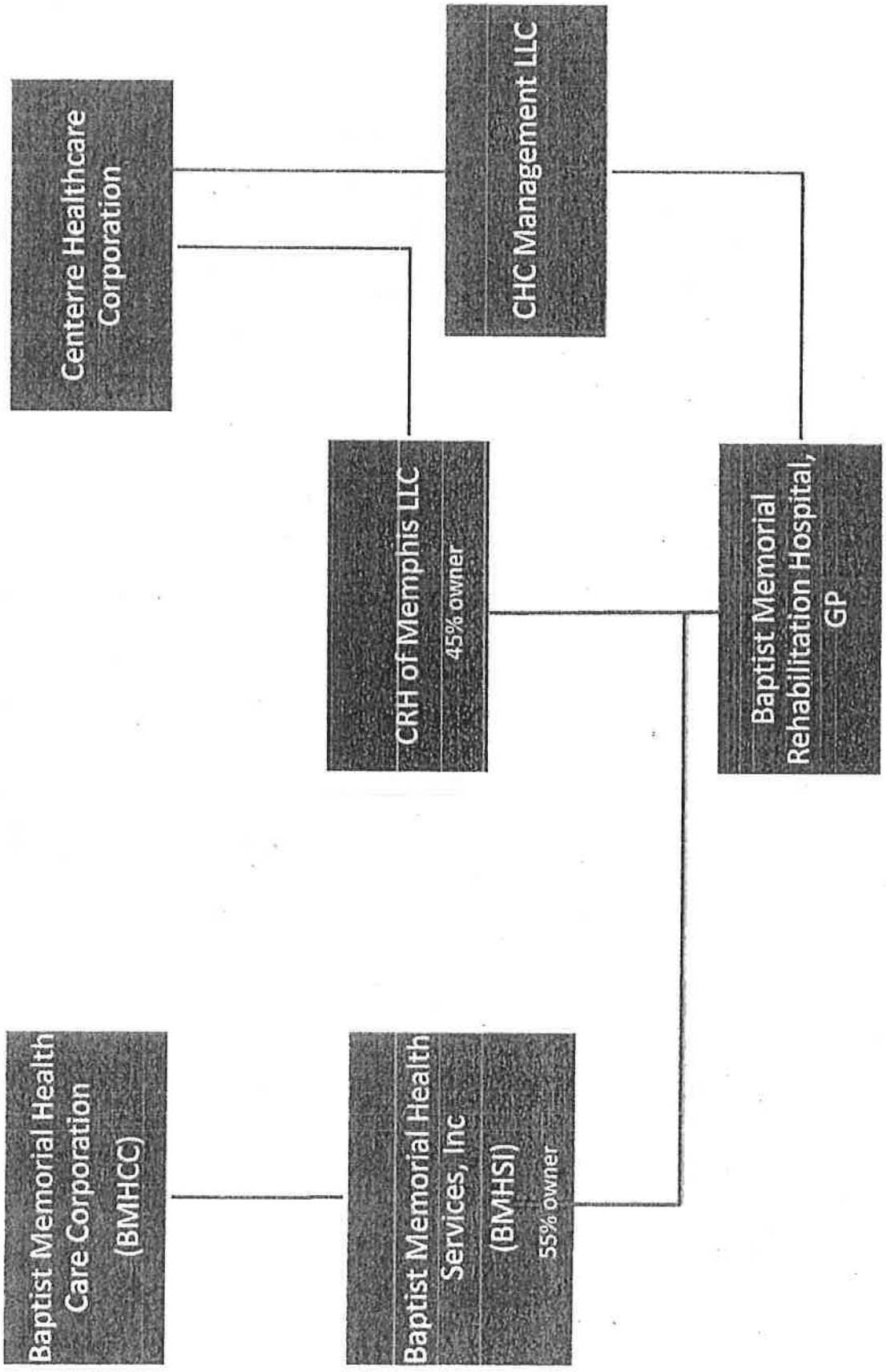
The Joint Venture Structure Chart previously submitted indicates some purchased services that are comprised primarily of radiology and other ancillaries such as lab. The Community Advisory Board that is also shown on the chart will consist of community members who may have been patients or had family members who were served at the Rehabilitation hospital. Advisory Board Members are selected based on the variety of backgrounds, experiences, and strengths each brings with the goal of accurately representing the community. Advisory Board Members receive updates on events and are asked to provide meaningful and constructive feedback and suggestions for enhancing services provided to the patients. Members will be asked to actively engage in issues or topics and will be given the opportunity to participate in hospital committees and teams of their choice where their talents and experiences will be beneficial.

The ownership structure chart that was previously submitted (copy attached for reference) is also explained by the chart on the following page. The *Ancillary Services* are shown along a broken line in the original chart from Baptist Memorial Health Care to the proposed Baptist Memorial Rehabilitation Hospital, G.P. The *Management Services,* are shown along a broken line from Centerre Healthcare to the proposed Baptist Memorial Rehabilitation Hospital, G.P. The proposed rehabilitation hospital acquires management services and ancillary services from partners and leases building and land from a third party developer as shown in the original chart.

Joint Venture Ownership Structure



SUPPLEMENTAL- # 1
December 27, 2012
2:41pm



3. Section A, Applicant Profile, Item 5

Please provide a brief description of the management/operating entity's expertise to operate the facility/service. Brief bios outlining areas of expertise and experience of the senior management will be helpful.

Please provide documentation of CHC Management Services, LLC corporate charter from the Tennessee Secretary of State.

Response
CHC Management is a subsidiary of Centerre Healthcare Corporation. Please refer to information about Centerre on the following pages.

Documentation from the Tennessee Secretary of State is also provided on the following pages.

Centerre Healthcare is dedicated to developing and operating rehabilitation hospitals in joint venture partnerships with major leading acute care hospitals, thereby expanding our partner's footprint, both clinically and geographically. Our programs focus on rehabilitation of higher acuity patients, especially neurological and trauma related conditions such as stroke, brain injury, spinal cord injury, burn, and various other traumatic injuries. Centerre has established a proven track record of improving clinical outcomes for its higher acuity patients in partner hospitals while at the same time driving improved financial performance.

By offering this combination of superior clinical outcomes, coupled with the lowest cost of care for higher acuity rehabilitation patients, Centerre believes it is best positioned to help our partners enhance their inpatient rehabilitation service line, holding true to the four fundamentals:

- **Value Delivery** – Centerre places defined and measurable clinical outcomes at the center of everything it does. Leveraging decades of rehabilitation specific experience (and success), we utilize our own compilation of key metrics and operational processes to drive superior quality, safety, and patient and family experiences, at a competitive price.

- **Increasing Scale** – Centerre provides the domain expertise, experience, and capital for a complete turnkey solution in a state-of-the-art, freestanding rehabilitation facility that is fully licensed and accredited. Our dedicated team allows us to simultaneously facilitate the design, construction, licensure and opening of multiple new facilities and maintain the operational focus and commitment necessary to deliver exceptional value to our partner and the community.

- **Network Capabilities** – The Centerre Model of care begins with building a closely integrated relationship with our hospital partner, their network of physicians and the care coordinators who are responsible for moving the patient through the system efficiently. The collaborative efforts focus on post-acute placement, taking into consideration all levels of inpatient care, including LTCH, IRF and SNF; and

- **Leadership and Culture** – With more than 70 years of combined experience, the key to Centerre's success and reputation in the market as a top rehab operator is its corporate management team. Members of the team have held executive level management positions in both not-for-profit and for-profit acute care and rehabilitation facilities. Such experience includes not only the successful operation of hospitals but also participation in market defining activities such as: the IRF-PPS Technical Expert Panel used by RAND and CMS to develop the prospective payment system for rehabilitation hospitals and participation in the design, development and presentation to CMS of a Pay for Performance system for Inpatient Rehabilitation Facilities.

To supplement its experienced management team, Centerre has developed a collaborative culture that encourages open communication and the sharing of best practices. Our Medical Director Advisory Board, Nursing Executive Advisory Board and Clinical Advisory Board bring together leaders from each joint venture hospital to discuss ways to enhance the quality of care and patient experience. Recommendations from these Advisory Boards are used to identify best practices, analyze delivery of care models, and provide additional training and other support to continuously improve the quality of comprehensive medical rehabilitation services.

Significant regulatory and reimbursement changes have increased the complexity and compliance risk of providing inpatient rehabilitation services, forcing some hospitals to close or re-evaluate their rehab programs. At the same time, the aging population and demand for post-acute services is increasing while patients seek to continue their independence after a devastating injury or illness. Partnering with Centerre Healthcare enables hospitals to continue to offer high quality inpatient rehabilitation services that meet their patient and physician needs, take advantage of any local rehab market consolidation, and achieve their financial goals.

VALUE OF THE PARTNERSHIP

Why should medical centers and health systems consider developing a joint venture freestanding inpatient rehabilitation hospital?

- Relocation of rehab services **frees up space** in the main medical center campus for core service expansion
- Facilitates **geographic expansion** of medical center / health system service umbrella
- Facilitates **branding** as "center of excellence" **and programmatic enhancements** like specialized brain injury treatment centers, and other Neurological services such as a Stroke Center of Excellence
- Freestanding rehab hospitals are typically seen as a more **visible community resource** which promotes census and program development
- Partnership model brings a **substantial additional annual revenue** stream to the medical center from ancillary services (e.g. radiology, lab) purchased by the rehab hospital
- Expanded rehab continuum facilitates the movement of patients through the hospital's care continuum by offering **high-quality clinical programs** and systems that concentrate on **optimal outcomes**
- A strong joint venture partner **shares the financial risk** of a new business entity and ensures a focus on operating results and clinical quality

BUSINESS MODEL

In our ***Joint Venture business model***, Centerre **and the partner medical center create** a formal **partnership** to develop and operate a state of the art free-standing Rehabilitation Hospital. Our innovative model limits the capital required from our partner to fund the venture. Specific components of the model are:

- Developer finances the land and building to **minimize capital investment** – facility is leased to the partnership entity
- Hospital partner contributes value of existing rehabilitation program (subject to third party valuation)
- Centerre contributes cash
- Respective ownership interest of the partners is determined by actual equity contributions
- Governance is shared equally between the partners
- The rehab facility is branded with the local hospital partner's name in order to facilitate local market recognition
- Centerre serves as the managing partner for a mutually agreed upon fee - compliance focus ensures that necessary regulatory requirements are met and all arrangements are at fair market value

CENTERRE ADVANTAGE

Centerre works only with market leading acute hospitals and health systems which promotes strategic and operating success of the joint venture and minimizes risk for both partners. Developing and operating a freestanding inpatient rehabilitation hospital is different than operating a hospital-based ("distinct part") unit. Centerre brings a turn-key solution and focus to our partnerships while at the same time respecting that each partnership and local market is unique. ***Inpatient rehabilitation is a small portion of a medical center's business – It's 100% of Centerre's.*** Unlike other companies, we only do rehabilitation partnerships. We support but do not compete with our hospital partners in other service lines and we are not distracted by other business interests such as long term acute care hospitals or skilled nursing facilities. With its impressive management team and expert capabilities, Centerre Healthcare may be the perfect solution for your rehabilitation program.

CENTERRE'S PARTNERS

We seek to partner with larger community-leading medical centers with a patient mix that would benefit from an expanded rehab program. Our growing list of hospital partners includes:

- **Lancaster General Health in Lancaster, PA**
  - 50-bed Lancaster Rehabilitation Hospital opened July 2007
  - Expanded to 59 beds
- **Mercy Hospital St. Louis in St. Louis, MO**
  - 50-bed Mercy Rehabilitation Hospital of St. Louis opened July 2007
  - Expanded to 90 beds
- **Methodist Health System in Dallas, TX**
  - 40-bed Methodist Rehabilitation Hospital opened January 2008
- **Waukesha Memorial Hospital in Waukesha, WI**
  - 40-bed The Rehabilitation Hospital of Wisconsin opened October 2008
- **Texas Health Resources – Harris Methodist Medical Center in Ft. Worth, TX**
  - 50-bed Texas Rehabilitation Hospital opened April 2011 – expanding by 16 beds
- **Mercy Health Center in Oklahoma City, OK**
  - 50-bed Free-standing rehab hospital opened October 2012
- **University Hospital in Cleveland, OH**
  - 50-bed Free-standing rehab hospital scheduled to open in Q1 2013
- **Community Health Network in Indianapolis, IN**
  - 60-bed Free-standing rehab hospital scheduled to open in Q2 2013
- **Saint Mary Medical Center in Langhorne, PA**
  - 50-bed Free-standing rehab hospital scheduled to open in Q3 2013

DISTINGUISHED OPERATING PERFORMANCE

Centerre's implementation and management team have effectively opened new rehabilitation hospitals at or under projected construction budgets and delivered a patient centered approach designed to integrate and support the partner hospital's continuum of care by:

- Building specialized programs and services to grow neurological patient mix
- Establishing quality benchmarks that meet or exceed UDS severity adjusted norms
- Developing strategic plans that include a focused marketing component to increase visibility and viability of inpatient rehabilitation services within the partner's healthcare system and community
- Providing resources as needed from Centerre's Physician Council, Nursing Executive Council, and CEO /Leadership meetings as well as offering network opportunities with our partners
- Expanding the partner's post-acute continuum of care to retain more patients within the system

EXECUTIVE MANAGEMENT TEAM

Patrick Foster, President and CEO of Centerre Healthcare, has more than 30 years of healthcare services experience, 21 of which have been devoted to operating rehabilitation hospitals. Mr. Foster's commitment to inpatient rehabilitation is demonstrated by Centerre's growth, strong relationships with its med-surge partners and superior patient outcomes under his leadership. During Pat's five year tenure at Centerre, two of the company's hospitals have been named to the Uniform Data System's (UDS) Top 10% in the Clinical Outcome Ranking; one of the hospitals was named to the list twice, once in 2009 and again in 2011. The Company's Clinical outcomes have been consistently well above the National reported outcomes. Centerre has been named to the Inc. 5000 ranking four years in a row.

Prior to Centerre, Mr. Foster served as President for the inpatient rehabilitation hospital division at HealthSouth Corporation with responsibility for 98 rehabilitation hospitals, multiple hospital based units, six long-term acute care hospitals and hospital-based home health care agencies. Mr. Foster also was a Senior Vice President of Operations for the Mediplex Group, Relife and Rehab Hospital Services Corporation (RHSC) before his tenure with HealthSouth. Early in his career Mr. Foster served as Vice President/Assistant Administrator for two large not-for-profit hospitals before entering the post-acute care industry. Under Mr. Foster's direction, his hospital operations have consistently exceeded national averages for clinical outcomes and patient satisfaction while generating strong financial results.

Jean Davis, Chief Operations Officer and Senior Vice President, has over 31 years of experience in the healthcare industry, most of which were devoted to overseeing the clinical programming and outcomes and case management functions within the inpatient rehabilitation industry including CEO experience of a new start up hospital. She also holds a Master Degree in Education with emphasis in counseling and a Bachelor of Science Degree in Physical Therapy. Ms. Davis has been responsible for directing and evaluating the effectiveness of clinical, regulatory and case-management services and systems for several large multi-hospital systems. She was a member of the IRF-PPS Technical Expert Panel used by RAND and CMS to develop the prospective payment system for rehabilitation hospitals. She has also participated in the design, development and presentation to CMS of a Pay for Performance design for Inpatient Rehabilitation Facilities. Ms. Davis coordinates and directs the operations of Centerre's joint venture hospitals.

Frank DiCesare, Senior Vice President of Operations, has over 20 years of healthcare experience in the public for-profit area. Most recently he served as the Vice President of Operations for a large rehabilitation and long term acute care hospital company. He served in various management roles including responsibilities for divisional financial operations, budgeting, development review, start-up operations, legislative activities, capital expenditures and commercial contracting. Mr. DiCesare has served on various Boards of Directors for joint venture partnerships and on the finance committee for the Federation of American Hospitals. He was also the controller and CFO of a 219-bed acute care medical center.

Rudy Blank, Chief Strategy and Development Officer, has over 15 years of experience working in both international public accounting firms and privately-held multi-national companies. He joined Centerre in 2008 and served as the Chief Financial Officer before transitioning into his current role in 2011. He has also held senior management positions with oversight including the finance, accounting, and supply-chain departments. Rudy has worked with one of the largest providers of care and services to seniors. He served as the controller for the nation's leading provider of outsourced perfusion, auto transfusion, anesthesia technician, and blood management services. He is a CPA and holds a Master of Business Administration degree. He is also a member of various financial and healthcare organizations.

William C. Bridges, M.D., National Medical Director, is a board certified physician by the American Board of Physical Medicine and Rehabilitation. He earned his medical degree from the University of Texas Southwestern Medical School at Dallas in 1997. Following his residency, Dr. Bridges focused on acute inpatient rehabilitation within the Dallas/Ft. Worth area. Prior to coming to the Texas Rehabilitation Hospital of Fort Worth as Medical Director, he worked closely with Texas Health Harris Methodist Fort Worth and their rehabilitation unit.

Julie Farris, Vice President of Human Resources, was the director of human resources for a nation-wide outpatient ambulatory surgery center company based in Nashville, TN. Her expertise was established during the creation and growth of the current human resources department for that company. She has extensive experience in the areas of employee relations, benefit administration, employee and manager coaching, recruitment, training and acquisition activities. Ms. Farris has a strong foundation in the areas of policy creation, compliance (including SOX) and internal audit controls. She is an active member of the Society for Human Resources Management (SHRM) and the American Society for Healthcare Human Resources Administration.

Eddie Gadsey, Chief of Information Technology, has over 18 years of experience working primarily in healthcare information technology. Most recently he served as CIO for an organization which owns and operates freestanding rehabilitation and psychiatric hospitals throughout the U.S. Mr. Gadsey also served as director of technical operations with an organization which owns and operates general, acute-care and behavioral hospitals and ambulatory surgery centers where he was responsible for overseeing new systems implementation.

Quality & Health Information

Debra Call, Corporate Director of Health Information, is a Registered Health Information Administrator (RHIA) with over 25 years of experience in health information services. She specializes in inpatient rehabilitation coding for prospective payment system reimbursement, and has expertise in acute care and long-term care PPS coding. She provides oversight and training for coding and reimbursement systems, and assures all HIPPA requirements are met in all partnership locations.

Theresa Hunkins, Vice President of Quality and Clinical Services, has more than 20 years of quality, compliance, risk management and healthcare operations experience. Ms. Hunkins' expertise is focused in the clinical operation areas of long term acute care and inpatient rehabilitation. She possesses extensive regulatory compliance experience specifically with Joint Commission and CMS. Ms. Hunkins' most recent role was Vice President and Chief Clinical Officer with a national acute rehabilitation and long term acute care hospital company, where she was responsible for the clinical and regulatory oversight of the organization. She has also served in Regional Operations, CEO, COO and Quality roles with national healthcare organizations. Ms. Hunkins is a Registered Nurse and also holds a Bachelor of Science in Healthcare Administration and a Master of Business Administration.

Development

Kelly Phelps, Vice President of Development, has a diverse background in healthcare transactions, as well as state and federal healthcare regulations. Prior to joining Centerre, Kelly led the legal and regulatory affairs departments for a start-up healthcare organization, as well as for a healthcare corporation specializing in rehab contract management and staffing. Her past experience includes structuring and executing multiple post-acute joint ventures with nationally recognized health systems, involving preservation of tax-exempt status, hospital-within-a hospital regulations, and compliance with Medicare fraud and abuse regulations. Ms. Phelps has a B.S. in accounting from the University of Houston, and a Juris doctorate from St. Louis University School of Law.

Darrell Simpson, Vice President of Development and Implementation, has over 24 years of healthcare design and construction experience. He has held senior management positions with two of the nation's more active healthcare builders providing project management, business development, and division operations leadership. He has also served nine years as vice president of program management for a national healthcare provider overseeing master planning, project development, and design and construction services. Darrell has managed the development of more than 13 Greenfield rehabilitation healthcare projects across the country.

Paul Murray, Vice President of Finance, is a CPA with a Master's degree in Accounting and a Bachelor's degree in Healthcare Management. Paul has over a decade of experience in accounting and finance. He has held management positions with areas of supervision including accounting and finance, and has served as a Principal and Chief Compliance Officer of limited investment partnerships with over $100 million in assets under management.

PARTNERSHIP REFERENCES

- **Lancaster General Health in Lancaster, PA**
  - 59-bed Lancaster Rehabilitation Hospital opened July 2007 - Expanded by 9 beds

Joe Byorick — fjbyoric@lancastergeneral.org
Chief Financial Officer — 717.544.4926
Lancaster General Health

Geoffrey W. Eddowes — gweddowe@lancastergeneral.org
Senior Vice President, Post-Acute Care — 717.544.0069
Lancaster General Health

- **Mercy Hospital (FKA St. John's Mercy) in St. Louis, MO**
  - 90-bed Mercy Rehabilitation Hospital St. Louis (FKA St. John's Mercy Rehabilitation Hospital) opened July 2007 - Expanded by 40 beds

Don Kalicak — Donald.Kalicak@mercy.net
Vice President, Regional Development — 636.614.3271
Mercy East Communities
Mercy Hospital St. Louis

- **Methodist Health System in Dallas, TX**
  - 40-bed Methodist Rehabilitation Hospital opened January 2008

Jonathan Davis — JonathanDavis@mhd.com
President — 214.947.7707
Methodist Charlton Medical Center

- **Waukesha Memorial Hospital in Waukesha, WI**
  - 40-bed Rehabilitation Hospital of Wisconsin opened October 2008

Kathy Scott — Kathy.scott@phci.org
Chief Innovation Officer — 262.928.2425
ProHealth Care

- **Texas Health Resources – Harris Methodist Medical Center**
  - 50-bed Texas Rehabilitation Hospital – opened April 2011 (expanding by 16 beds)

Lillie Biggins — lilliebiggins@texashealth.org
Senior Vice President, Operations — 817.250.3722
Texas Health Resources - Corporate

Joseph DeLeon — JosephDeLeon@texashealth.org
Vice President Professional Services & Bus. Dev. — 817.250.4657
Texas Health Resources – Harris Methodist

- **Mercy Hospital in Oklahoma City, OK**
  - 50-bed Mercy Rehabilitation Hospital Oklahoma City opened October 2012

Don Kalicak — Donald.Kalicak@mercy.net
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Mercy East Communities
Mercy Hospital St. Louis

4. Section A, Applicant Profile, Item 9

Please provide a bed complement data table for Baptist Rehabilitation-Germantown reflecting the de-licensing of forty-nine (49) rehabilitation beds.

Response
A bed complement table for Baptist Rehabilitation-Germantown follows this page.

9. **Bed Complement Data**

Please indicate current and proposed distribution and certification of facility beds.

(Note: The beds below will be at the proposed new hospital, although the project involves a relocation of beds from an existing facility. Please refer to explanation below)

		Current Beds Licensed	**CON*	*Staffed Beds*	*Beds Proposed*	*TOTAL Beds at Completion*
A.	Medical	1				1
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation *(Please see note below)*	49		40	-49	0
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)	18		18		18
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)					
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL	68		58	-49	19

*CON-Beds approved but not yet in service

Explanation Note** Nursing home beds are separately licensed.

5. Section B, Project Description, Item I

Please indicate the future of the proposed forty-nine (49) bed BRG de-licensed rehabilitation unit space.

Response:

Plans are still in process regarding the future use of the space at Baptist Rehabilitation – Germantown.

The management/operating entity of CHC Management Services, LLC is noted. Please indicate who is currently managing the BRG forty-nine (49) bed rehab unit. What are the advantages of contracting with CHC Management Services over the current management arrangement?

Response

Current management of the 49 bed rehabilitation unit is by the hospital itself, Baptist Memorial Regional Rehabilitation Services, d/b/a Baptist Rehabilitation-Germantown. To continue providing the rehabilitation services in a coordinated manner reflective of changes in the industry, Baptist Memorial has sought a partner that has experience in making programmatic enhancements in neurological and other services focused on current solutions to providing effective rehabilitation services. With an established management team, experience in partnership governance, and experience in meeting the regulatory requirements with a model that minimizes capital investment. Centerre was chosen as the appropriate partner for the rehabilitation services at Baptist Memorial Rehabilitation Hospital.

A proposed forty-nine (49) private bed rehab facility is noted. What is the cost of a semi-private bed compared to a private bed? Also, are there instances where a semi-private room is appropriate for companionship?

Response

The current charge at Baptist Rehabilitation-Germantown for a private or semi-private bed is $1,776. The projected charge at the proposed hospital is anticipated to be approximately the same adjusted for inflation.

There is still some debate within the healthcare community regarding the use of private rooms versus semi-private rooms in a hospital setting. Some say that single-rooms may cause social isolation rather than social support. However, the benefits of private rooms far outweigh the disadvantages, particularly within the context of providing inpatient rehabilitation services. The proposed new hospital would provide specialized services that would focus on patients with a high level of acuity: stroke, neurological disorders, brain injuries, etc. The benefits of private rooms for this type of patient include infection control, privacy, family support, lower fall rates, etc. Additionally, the freestanding inpatient rehabilitation hospital offers features that mitigate the perceived disadvantages of private rooms including dining rooms, therapy gyms and day rooms that allow for patient socialization.

Please provide a copy of a study that supports private beds are favored over semi-private beds in a rehabilitation unit.

Response

Various articles are available discussing the benefits of private patient rooms. The rationale in a rehabilitation hospital is the same as for all other acute hospitals. For example, if single patient rooms are more appropriate for acute care patients in order to decrease the spread of hospital-acquired infections, then it might be said that the same would hold true for rehab patients with an even longer length of stay.

Three items are provided following this page:

1) A summary of the relationships between design factors and healthcare outcomes published in Health Environment Research and Design Journal and issued in Spring 2008 in ***A Review of the Research Literature on Evidence –Based Healthcare Design (Part II) The summary states that single-bed rooms are the design intervention that positively effects the largest number of outcomes in a hospital setting.***
2) A Wall Street Journal article published on March 22, 2006, New Standards for Hospitals Call for Patients to Get Private Rooms.
3) An excerpt from the 2010 Edition of the Guidelines for Design and Construction of Health Care Facilities, often called the AIA Guidelines, from the Facility Guidelines Institute recommending a single-need patient room.

Please provide an overview of the specialized stroke/neurological programs that will be offered at the proposed site. How will these programs increase utilization?

Response

The new Joint Venture rehabilitation hospital offers specialized medical inpatient rehabilitation, including dedicated Stroke and Brain Injury units. These dedicated units are designed to create an environment that promotes the patient's functional performance at the highest possible level. The state-of-the-art Stroke and Brain Injury units include new and enhanced features such as specialized beds, monitoring equipment, and dedicated treatment areas. The designated team of trained rehabilitation specialists under the direction of the Physical Medicine and Rehabilitation physician utilizes best practice care models to deliver high quality programs and services designed to meet specialized accreditation standards of The Joint Commission and CARF.

The current Baptist Rehabilitation-Germantown is the only provider in Memphis that has achieved CARF accreditation for Stroke and Brain Injury. The new hospital expects to achieve CARF accreditation for these specialties as part of its mission to enhance the specialized programs that are provided to Memphis and the region. In this way, a Center of Excellence will be established for the community. The proposed new hospital will provide a setting to develop specialized programs that will increase utilization of the 49 inpatient beds.

design strategies and interventions that can influence outcomes. The main body of this paper was organized by type of healthcare outcome. However, designers and healthcare workers often face the question of whether to employ specific design strategies or interventions. Therefore, the following sections discuss specific design measures and the improved outcomes that can be expected from them. Table 1 provides an overview of the relationships between design factors and healthcare outcomes. It should be noted that some of the relationships indicated in this table have not been directly tested by empirical studies, but they have been supported in an indirect way by strong available evidence.

Summary of the Relationships Between Design Factors and Healthcare Outcomes

Design Strategies or Environmental Interventions / Healthcare Outcomes	Single-bed rooms	Access to daylight	Appropriate lighting	Views of nature	Family zone in patient rooms	Carpeting	Noise-reducing finishes	Ceiling lifts	Nursing floor layout	Decentralized supplies	Acuity-adaptable rooms
Reduced hospital-acquired infections	**										
Reduced medical errors	*		*				*				*
Reduced patient falls	*		*		*	*			*		*
Reduced pain		*	*	**			*				
Improved patient sleep	**	*	*				*				
Reduced patient stress	*	*	*	**	*		**				
Reduced depression		**	**	*	*						
Reduced length of stay		*	*	*							*
Improved patient privacy and confidentiality	**				*		*				
Improved communication with patients & family members	**				*		*				
Improved social support	*				*	*					
Increased patient satisfaction	**	*	*	*	*	*	*				
Decreased staff injuries								**			*
Decreased staff stress	*	*	*	*			*				
Increased staff effectiveness	*		*				*		*	*	*
Increased staff satisfaction	*	*	*	*			*				

Single-Bed Rooms

The design intervention that positively affects the largest number of outcomes in a hospital setting is the provision of single-bed patient rooms. The value of single-bed rooms has been acknowledged by the AIA after extensive research and has been included in the *2006 Guidelines for Design and Construction of Health Care Facilities* (AIA & FGI, 2006). Strong evidence indicates that single-bed rooms improve the following outcomes:

Hospital-Acquired Infections. The use of single-patient rooms reduces airborne, contact, and waterborne transmission of hospital-

acquired infections by increasing isolation capacity, facilitating the thorough cleaning of rooms and the maintenance of air quality, and also possibly increasing hand-washing compliance by healthcare workers.

Patient Sleep. Patients in single-bed rooms benefit from increased privacy and the reduction in noise from roommates, visitors, and healthcare staff. These factors improve sleep and facilitate the healing process.

Patient Privacy. Single-bed rooms help protect auditory and visual privacy compared with multibed rooms. The absence of a roommate in hospital rooms helps prevent privacy breaches during discussions between patients and care providers. Patients in single-bed rooms are more willing to provide personal information to care providers, which facilitates diagnosis and treatment.

Communication with Patients and Families. Because of enhanced auditory privacy, single-bed rooms can improve communication among patients, families, and care providers. Patients in single-bed rooms report greater satisfaction with communication from nurses and physicians compared with patients in multibed rooms.

Social Support. Compared with multibed rooms, single-bed rooms provide enhanced privacy, encourage family visits and social interaction, and are more likely to provide space to accommodate visiting relatives and friends.

Staff Stress. Staff also appreciates the benefits of single-bed rooms and reports finding them less stressful than multibed or open-bay settings.

Patient Satisfaction. Considering all the above-mentioned benefits, it is no surprise that patients are more satisfied with their hospital stays when they are placed in single-bed rooms.

Access to Daylight and Appropriate Lighting

The quality and quantity of daylight exposure and artificial lighting is associated with several patient and staff outcomes in healthcare settings. Access to daylight is important for both staff and patients. For patients, it has been found to reduce pain and the incidence of depression, and for certain types of patients, it also may reduce length of stay. For staff, access to daylight contributes to higher satisfaction. Therefore, site planning and the orientation of healthcare facilities should be carefully considered to ensure sufficient daylight and avoid situations where some buildings block light for others. Larger windows in patient rooms not only provide natural light, but they also have the potential benefit of offering views of nature and should be considered in the design process.

The amount and timing of light in healthcare settings should be tailored to the activities that take place in them. In general, sufficient lighting is beneficial to both patients and staff. Bright lighting is preferred in areas where staff performs critical tasks such as medication dispensing.

Medical Errors. Research has found that medication-dispensing errors are lower when the level of work-surface lighting is relatively high, compared to situations with lower levels of lighting. While other areas of the hospital have not been tested, it is logical to infer that bright lighting would also be useful in other places where precision is called for.

Pain. Exposure to natural light has been found to reduce patients' pain and the amount of pain medications that they use. Buildings should be carefully designed so that patient rooms can have abundant natural light.

Patient Sleep. As a major contributor to normal circadian rhythm, the amount of light that patients are exposed to at different times of day can affect sleep quality. During the day, patients should be exposed to adequate natural light or bright artificial lighting when natural light is not available. At nighttime, if possible, the light in patients' rooms should be dimmed long enough to ensure good sleep.

Depression. A considerable body of rigorous evidence indicates that exposure to light—daylight or bright artificial light—is effective in reducing depression and improving mood. These findings underline the importance of building orientation and site planning in new healthcare projects.

Length of Stay. Research on patients suffering from depression found that patients in rooms with more morning daylight had shorter lengths of stay than patients in rooms without morning sunlight.

Communication with Patients and Families. Research on counseling rooms suggests that people feel more comfortable talking and talk longer in rooms with dim lighting as compared to similar rooms with bright lighting.

THE WALL STREET JOURNAL.
WSJ.com

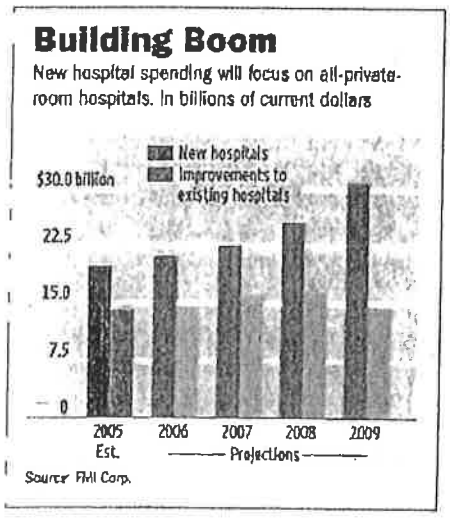
THE INFORMED PATIENT | March 22, 2006

New Standards for Hospitals Call For Patients to Get Private Rooms

By LAURA LANDRO

The private patient room, once a luxury for the privileged few, is about to become the standard for the nation's hospitals, as evidence mounts that shared rooms lead to higher infection rates, more medical errors, privacy violations and harmful stress.

New guidelines for hospital design, due out next month, will for the first time call for single-patient rooms as a minimum requirement for most new hospital construction. Published every four years by the nonprofit Facilities Guidelines Institute and the American Institute of Architects' Academy of Architecture for Health, the guidelines are used by more than 40 state governments to set regulations, approve construction plans and license hospitals to operate.



With growing concern about infection risk and pandemic disease outbreaks, the guidelines will also include other new safety recommendations, including more areas in hospitals that can be quickly isolated during an infectious-disease outbreak, and better ventilation systems to thwart the spread of bacteria.

The new guidelines apply only to new construction. But they will influence a significant proportion of the nation's approximately 6,000 hospitals, which are already launching a building boom to meet demand from an aging population and replace obsolete facilities.

Mark Bridgers, a senior consultant at construction research firm FMI Corp., estimates that spending on new construction alone -- including hospitals tearing down old facilities to rebuild or starting from scratch on new sites -- will exceed $30 billion by 2009, up from about $19.8 billion last year. And the majority of new projects are for all-private rooms, according to health-care architects and construction firms.

The guidelines will add to growing competitive pressure on existing facilities to shift to the all-private model when practical. The trend toward all-private-room designs began a few years ago as

hospitals vied for patients by offering better amenities and more comfortable facilities where family members can stay overnight in patient rooms. Affluent baby boomers, too, have been willing to shell out extra out-of-pocket expenses for private rooms.

But the driving force behind all-private rooms is coming down to better patient safety -- and better economics. "Unless there are extenuating circumstances, for most hospitals the semiprivate room will be a thing of the past," says Scot Latimer, a consultant at Kurt Salmon Associates and president of the health architecture group. While it may cost more to build hospitals with all-private rooms initially, he says, "they pay for themselves very quickly and are much less expensive to operate" in the long run.

In facilities that have a mix of private and semiprivate rooms, private rooms can cost hundreds of dollars more per day and are rarely covered by insurance unless deemed medically necessary. But with the all-private model, a hospital has just one rate, which Medicare, Medicaid and private insurers must cover, hospitals say. Many existing hospitals that have converted to all-private say they have met insurers halfway by continuing to charge their old semiprivate rates for all rooms.

Insurance companies increasingly reimburse hospitals for patients on a per diem basis, and the room rate may range from 10% of that charge to a third, depending on the severity of the case. A spokeswoman for insurer Aetna Inc., for example, says that in many cases, it is up to hospitals to allocate how the reimbursement is divided among room and other charges.

One reason the guidelines may actually reduce costs: Patients recover faster in private rooms. They are less susceptible to disease transmission, and are less likely to get the wrong medication or experience other medical errors because they were confused with a roommate. And studies show patients sleep better and maintain better spirits when there isn't another patient snoring or coughing in a nearby bed and they see only their own relatives and visitors.

Operating and labor costs are also less than for semiprivate rooms because patients don't have to be transferred as often. And with no need to make sure male and female patients have roommates of the same sex, hospitals can actually run at higher occupancy, notes Craig Zimring, a professor at the Georgia Institute of Technology and co-author of a report to the nonprofit Center For Health Design, which conducts research on optimal hospital facilities.

Private rooms help reduce patient falls, which can add $10,000 in extra costs. In private rooms, among other things, patients often have relatives around for assistance and have less equipment and furniture to maneuver around. Private rooms also allow full use of hospital beds, while hospitals with semiprivate rooms often have 10% or more of beds unoccupied.

Numerous studies show that infection rates are lower in private hospital rooms, for fairly obvious reasons: Patients don't have to share a bathroom where bacteria lurk, and they aren't exposed to airborne infections that waft over from a roommate. In shared rooms, staffers may touch both patients without washing their hands between contacts, or after touching privacy curtains, blood-pressure cuffs, computer keyboards and other equipment used for both patients in a room.

With added costs from infections and other risks in shared rooms, "we can't afford to operate U.S. hospitals that have anything other than private rooms," Mr. Zimring says.

At Bronson Methodist Hospital in Kalamazoo, Mich., which built a new all-private-room hospital in 2000 with hand-washing stations in each room, a study showed a 45% decline in infection rates in the new hospital compared with an older facility with semiprivate rooms that it closed after the new one was completed. The private rooms required more space per patient and cost more to build, but

savings in operational costs from the reduced infection rates offset the initial capital expense, the hospital says. Bronson says room charges in its new facility were based on the semiprivate rate before the move.

Richard Van Enk, the epidemiologist at Bronson and co-author of the study, also says new federal privacy regulations are almost impossible to enforce in shared rooms, where every consultation with a doctor or nurse can possibly be overheard. "If I were ill and dealing with a disease, I can't imagine wanting a complete stranger sharing that experience," he says.

That was the case for Ann Nieuwenhuis, an educator and researcher at Michigan State University, who was treated in a private room at Bronson after an auto accident last year. "Just being able to have the trauma surgeon come in and not have to speak in hushed tones about my treatment was a relief," she says. Her husband was able to stay in the room, it was quiet enough to sleep, and she didn't have to worry about personal privacy or disturbing a fellow patient.

HCA Inc., the largest for-profit hospital company, with 182 hospitals, already recommends that its hospitals make the shift to private rooms when building new facilities. While private rooms can mean extra walking time between rooms for nurses and other staff, they reduce the need to move around equipment that might spread infection, notes Jane Englebright, vice president for quality programs. Patients also find there is a much better "healing environment," she says, "because you don't have issues like roommates who don't like the same TV program or don't like your family."

Some experts warn that not all hospitals can afford to convert to all-private rooms. In dense urban areas, there may not be enough real estate to expand, and in rural areas that need to serve a widely spread population, hospitals may not find it feasible to build a facility large enough to give them all private rooms. Hospitals also must have "surge capacity" -- the ability to add beds in an emergency or disease outbreak.

"If the choice is one patient in a private room and the other one in the hallway, two in a room is obviously better for patients," says Dale Woodin, deputy executive director of the American Hospital Association's health-care engineering society.

Joseph G. Sprague, senior vice president at Dallas health-care design firm HKS Inc. and chairman of the health-care guidelines revision committee, says the guidelines provide an exception to the private-room standard if hospitals can demonstrate "the necessity of a two-bed arrangement," which might include the need to handle surge capacity in regions such as the Southeast, where there is a big seasonal population influx. There may also be some "therapeutic value in having more than one patient in a room," such as rehabilitation hospitals, where it can be encouraging for patients to see each other's progress, he adds.

At Proctor Hospital in Peoria, Ill., which began a gradual shift to all-private rooms starting in 1997, Chief Operating Officer Garrett McGowan says its 128 private rooms are large enough and designed to add a second patient in the event of need. "We can convert back to semiprivate and we've had to do that from time to time," Mr. McGowan says.

Chicago's Northwestern Memorial Hospital found that patient satisfaction scores went up sharply after the hospital switched to all-private rooms in 1999 -- and the 500-bed hospital is now able to provide equal accommodations for both affluent and less-well-off patients. "Every single patient deserves a private room, and it doesn't matter whether they are rich or poor," says Jean Przybylek, vice president of operations.

- Email me at informedpatient@wsj.com.

SUPPLEMENTAL- # 1
December 27, 2012
2:41pm

How will the relocation of the proposed 49 bed rehab unit affect the existing 18 bed skilled nursing unit at BRG? Please clarify if the BRG 18 bed skilled nursing unit has been experiencing the same utilization trends as the existing 49 bed rehab unit (a reduction in days from 2009-2011).

Response

Operation of the existing 18 bed skilled nursing unit, separately licensed as Baptist Skilled Rehabilitation Unit-Germantown, is expected to continue without interruption. The utilization of the SNF is continuing with high utilization and is not experiencing the same trends as the Rehabilitation facility.

Please clarify if outpatient services will be offered at the proposed site.

Response

Outpatient services will continue to be offered at the current hospital site in Germantown. The proposed Baptist Memorial Rehabilitation Hospital will focus on providing inpatient rehabilitation services only.

The applicant is referencing Joint Ownership Venture Ownership Structure-Exhibit B.3. This exhibit could not be found in the application. Please clarify.

Response

The Reference to Exhibit B.3 is a transcription mistake that should refer to Exhibit A.4. A corrected page 7 is provided.

On page 8 there appears to be an error in the referenced lease costs ($33,167,900). Please correct and submit a replacement page.

Response

The transcription mistake has been corrected and a corrected page 8 is provided,

Excerpt from p. 203 Guidelines for Design and Construction of Health Care Facilities 2010 Edition

2.6 Specific Requirements for Rehabilitation Hospitals and Other Facilities

2.6-2.2 Rehabilitation Nursing Unit

2.6-2.2.1 Application

Each patient room shall meet the following standards:

2.6-2.2.2 Patient Room

2.6-2.2.2.1 Capacity

(1) The maximum number of beds per room shall be one unless the approved functional program demonstrates the necessity of a multi-bed arrangement. Approval of a multi-bed arrangement shall be obtained from the authority having jurisdiction.

(2) Larger units shall be permitted if justified by the functional program.

(3) At least two single-bed rooms with private toilet rooms shall be provided for each nursing unit.

2.6-2.2.2.2 Space requirements

(1) Area. Patient rooms shall have a minimum clear floor area of 140 square feet (13.01 square meters) in single-bed rooms and 125 square feet (11.61 square meters) per bed in multiple-bed rooms.

Please clarify if outpatient services will be offered at the proposed site.

Response

Outpatient services will continue to be offered at the current hospital site in Germantown. The proposed Baptist Memorial Rehabilitation Hospital will focus on providing inpatient rehabilitation services only.

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Response

The transcription mistake has been corrected and a corrected page 8 is provided,

6. Section B, Project Description, Item II.A.

Please indicate if the proposed facility will be AIA compliant. Please indicate the dimensions of the proposed patient rooms.

Response
The proposed facility will be AIA compliant. The letter from the architect provided as Exhibit - Economic Feasibility 1 references the *Current edition of FGI Guidelines for the Design and Construction of Healthcare Facilities* as the first item. This publication is often referred to as the AIA Guidelines.

The patient rooms will be approximately 285 square feet in an area. The toilets are inboard and the 12' x 13' clear floor area that the AIA guidelines require is provided.

7. Section B, Project Description, Item II.C.

Of the thirteen specific diagnoses defined by CMS as part of the 60 percent rule, which ones does the applicant anticipate will be referred to the proposed inpatient rehabilitation service? Please provide the projection numbers for each of the anticipated diagnoses and the methodology used to reach the projection numbers.

Response:
As referenced in other sections of the application, the 13 qualifying medical conditions used to classify a facility as an IRF are:"

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma
- Hip fracture
- Brain injury
- Neurological disorders
- Burns
- 3 arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed, and
- Joint replacement for both knees or hips when the surgery immediately precedes admission, when the BMI >=50, or age 85+

The Centerre model outlined in the application that is based on discharges from BMH-Memphis and BMH-Collierville provided the following figure that demonstrates sufficient need for the proposed project. As shown in the figure, discharges from the acute facilities provides a potential compliant Average Daily Census (ADC) of 51.4 and a non-compliant potential ADC of 27.7 for a total rehab potential ADC of 79.1.

Baptist Memphis and Baptist Collierville - All Payer Data
FY 2010

DRG #	Area/RIC	# of All Payor Cases	DRG #	Area/RIC	# of All Payor Cases	RIC	Description	DRG CROSS REF	Total # of All Payor Cases
20	3	21	241	10	1				
21	3	8	255	11	1	1	Stroke	61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72	1,242
22	3	7	256	11	3				
23	3	32	257	11	-				
24	3	5	453	9	4				
25	3	69	454	9	5	2	Traumatic Brain Injury	26, 27, 82, 83, 84, 85, 86, 87, 88	271
26	2	57	455	9	5				
27	2	87	459	9	19				
28	5	13	461	8	2	3	Non Traumatic Brain Injury	20, 21, 22, 23, 24, 25, 31, 37, 75, 76, 77, 78, 79, 80, 81	241
31	3	10	462	8	16				
37	3	32	466	9	6	4	Traumatic Spinal Cord Injury		-
38	6	28	467	9	34				
39	6	101	468	9	24	5	Non Traumatic Spinal Cord Injury	28, 52, 53	18
41	6	22	469	8	79				
42	6	17	470	8	543				
52	5	2	471	9	18	6	Neurological	38, 39, 41, 42, 54, 55, 56, 57, 58, 59, 60, 73, 74, 91, 92, 93, 97, 98, 99,100, 129, 130, 149	812
53	5	3	474	10	6				
54	6	44	475	10	7				
55	6	36	476	10	1	7	Fracture of lower extremity	480, 481, 482, 533, 534, 535, 536	312
56	6	31	480	7	90				
57	6	54	481	7	117				
58	6	3	482	7	42	8	Replacement of lower extremity joint	461, 462, 469, 470, 483, 484	709
59	6	11	483	8	14				
60	6	16	484	8	55				
61	1	7	490	9	72				
62	1	7	507	9	1	9	Other Orthopedic	453, 454, 455, 459, 466, 467, 468, 471, 490, 507, 508, 515, 539, 540, 541, 542, 543, 544, 545, 548, 549, 550, 553, 559, 560, 561	379
63	1	1	508	9	4				
64	1	304	515	9	13	10	Amputation, lower extremity	239, 240, 241, 474, 475, 476, 616, 617, 618	76
65	1	208	533	7	1				
66	1	157	534	7	6				
67	1	11	535	7	10	11	Amputation, non-lower extremity	255, 256, 257	4
68	1	25	536	7	46				
69	1	248	539	9	15	12	Osteoarthritis		-
70	1	148	540	9	15	13	Rheumatoid		-
71	1	88	541	9	2	14	Cardiac		-
72	1	38	542	9	30	15	Pulmonary		-
73	6	60	543	9	30	16	Pain Syndrome		-
74	6	127	544	9	11				
75	3	11	545	9	18	17	MMT without Brain or Spinal Cord Injury	183, 184, 185, 913, 914, 956, 957, 958, 959, 963, 964, 965	52
76	3	12	548	9	4				
77	3	13	549	9	2	18	MMT with Brain or Spinal Cord Injury	955	1
78	3	11	550	9	1				
79	3	5	553	9	18	19	Guillan Barre		-
80	3	1	559	9	5				
81	3	4	560	9	12	20	Burns	927, 928, 929, 933, 934, 935	6
82	2	4	561	9	11				
83	2	2	616	10	2	21	Miscellaneous		-
84	2	7	617	10	12				
85	2	31	618	10	-				
86	2	39	913	17	4				
87	2	36	914	17	11				
88	2	8	927	20	-				
91	6	26	928	20	2				
92	6	44	929	20	-				
93	6	43	933	20	-				
97	6	3	934	20	1				
98	6	4	935	20	3				
99	6	2	955	18	1				
100	6	84	956	17	4				
129	6	7	957	17	1				
130	6	1	958	17	-				
149	6	48	959	17	1				
183	17	4	963	17	7				
184	17	4	964	17	4				
185	17	6	965	17	4				
239	10	29							
240	10	18							
					4,123				4,123

Rehabilitation Bed Need Analysis
Baptist Memorial Hospital - Memphis & Collierville

Source: Hospital Data - Baptist Memorial Date Period: FY 2010				All Payor Cases		
Diagnostic Category	Total of All Payor Cases	Average Length of Stay	Percent Requiring Rehab	Rehab Aprop. Cases	Projected Rehab Patient Days	Projected Rehab ADC
Stroke	1,242	17.6	40%	497	8,744	24.0
Traumatic Brain Injury	271	17.6	30%	81	1,431	3.9
Non Traumatic Brain Injury	241	15.6	30%	72	1,128	3.1
Traumatic Spinal Cord Injury	-	27.2	50%	-	-	-
Non Traumatic Spinal Cord Injury	18	18.0	25%	5	81	0.2
Neurological	812	14.3	40%	325	4,645	12.7
Fracture of lower extremity	312	13.8	25%	78	1,076	2.9
Replacement of lower extremity joint	709	10.8	5%	35	383	1.0
Other Orthopedic	379	12.7	15%	57	722	2.0
Amputation, lower extremity	76	13.5	15%	11	154	0.4
Amputation, non-lower extremity	4	13.1	10%	0	5	0.0
Osteoarthritis	-	11.3	10%	-	-	-
Rheumatoid	-	10.6	10%	-	-	-
Cardiac	-	11.9	10%	-	-	-
Pulmonary	-	12.9	1%	-	-	-
Pain Syndrome	-	10.5	1%	-	-	-
MMT without Brain or Spinal Cord Injury	52	13.8	50%	26	359	1.0
MMT with Brain or Spinal Cord Injury	1	21.6	50%	1	11	0.0
Guillan Barre	-	14.0	80%	-	-	-
Burns	6	16.5	25%	2	25	0.1
	4,123			1,190	18,763	51.4

ALL PAYOR	
Estimated All Payor ADC	51.4
Selected DRGs	
Adjusted 35% for all other DRG's	79.1
Add additional 35% for non-compliant cases	

Please Note: ALOS has been updated as of 4/25/11 by the Nation Adjusted Mean LOS from UDS.

Using the above chart as the model for patient access, the first year's cases and days are shown in the figure below. Applying a 4 quarter ramp-up for the new hospital, the projection conservatively assumes a primarily compliant (within the 13 medical conditions) census resulting in 785 cases and 11,095 patient days in year 1.

Diagnostic Category	Potential Rehab Patient Days	Potential Rehab ADC	Projected LOS	YEAR 1 Projected Days	YEAR 1 Projected Cases
Stroke	8,743.68	23.96	16.00	5,200	325
Traumatic Brain Injury	1,430.88	3.92	16.00	848	53
Non Traumatic Brain Injury	1,127.88	3.09	15.00	645	43
Traumatic Spinal Cord Injury	0.00	0.00		0	0
Non Traumatic Spinal Cord Injury	81.00	0.22	16.00	48	3
Neurological	4,644.64	12.73	14.50	2,755	190
Fracture of lower extremity	1,076.40	2.95	13.90	639	46
Replacement of lower extremity joint	382.86	1.05	5.20	229	44
Other Orthopedic	722.00	1.98	7.25	428	59
Amputation, lower extremity	153.90	0.42	13.00	91	7
Amputation, non-lower extremity	5.24	0.01		0	0
Osteoarthritis	0.00	0.00		0	0
Rheumatoid	0.00	0.00		0	0
Cardiac	0.00	0.00		0	0
Pulmonary	0.00	0.00		0	0
Pain Syndrome	0.00	0.00		0	0
MMT without Brain or Spinal Cord Injury	358.80	0.98	14.14	212	15
MMT with Brain or Spinal Cord Injury	10.80	0.03		0	0
Gullian Barre	0.00	0.00		0	0
Burns	24.75	0.07		0	0
Total	18,762.83	51.41	7.46	11,095	785

8. Section B, Project Description, Item IV (Floor Plan)

Please indicate if the proposed facility will be AIA compliant. Please indicate the dimensions of the proposed patient rooms. Are there any minimum requirements for the dimensions of patient rooms?

Please clarify if the proposed building structure is designed to add additional rehab beds in the future if needed.

Response

As discussed in response to a previous item, the proposed facility will be AIA compliant. The letter from the architect provided as Exhibit Economic Feasibility 1 references the *Current edition of FGI Guidelines for the Design and Construction of Healthcare Facilities* as the first item. This publication is often referred to as the AIA Guidelines. The minimum requirement for the open area in a patient room from the FGI Guidelines is :

2.6-2.2.2.2 Space requirements

(1) Area. Patient rooms shall have a minimum clear floor area of 140 square feet (13.01 square meters) in single-bed rooms and 125 square feet (11.61 square meters) per bed in multiple-bed rooms.

The proposed structure has the capability to add beds in the future if needed.

9. **Section C. Need (Specific Criteria- Comprehensive Inpatient Rehabilitation Services) Item 7**

   Please describe in detail the applicant's experience with recruiting physiatrists and other related physician specialties.

Response:
Baptist Memorial Health Care Corporation has recruited physiatrists and other physician specialists for the current Baptist Rehabilitation-Germantown facility as well as other units in DeSoto County, MS and Oxford, MS.

Centerre Healthcare Corporation is currently involved in the co-ownership and management of 9 inpatient rehabilitation facilities in 8 states. It has an established record of successfully recruiting physiatrists and other physicians to serve these facilities, and Centerre will use its recruiting experience and contacts to assure that appropriate physicians and other clinicians are available to meet the needs of patients in the facility.

10. Section C. Need Item 3

Please provide a State of Tennessee map that clearly provides an outline of all counties.

Response
A map showing all counties in Tennessee follows this page.

11. Section C. Need Item 4 (b).

The applicant's response is noted. Other than a growing population of the age 65 and over, please describe any special needs of the Shelby County area population including health disparities, accessibility to services, woman, racial, ethnic minorities, and low income groups. In your response, please document how the applicant will take into consideration the special needs of the population.

Response:
The proposed new state-of-the-art facility will increase the inpatient rehabilitation capacity and allow improvements in service that will increase patient access and encourage participative effort in specialized therapies, and improve satisfaction.

Inpatient rehabilitation is particularly effective for patient populations with a large number of stroke/neurological disorders, as well as musculoskeletal and medically complex disabling conditions, a majority of which fall within the nervous system disorders or Major Diagnostic Category 1 (MDC 1). Baptist Memorial Hospital in Memphis and Collierville is responsible for a large population of patients with these diagnoses (approximately 3,000 total MDC 1 discharges in Shelby County). Establishing a state-of-the-art freestanding rehabilitation hospital, with specialized clinical services focused on such conditions ensures that the capability of providing high quality care will be available to these patients.

The service need is also demonstrated by the CARF accreditation for Stroke and Brain Injuries. CARF is an independent, nonprofit organization that focuses on advancing the quality of services and evaluating healthcare providers' commitment to continually improving services and serving the community. The new hospital expects to achieve CARF accreditation for these specialties as part of its mission to enhance the specialized programs that Baptist provides to the Memphis and Shelby County community. In this way, the joint venture will establish a "Center of Excellence" that is not currently available to the community.

12. Section C. Need Item 6

Please clarify why beds decreased at BRG from 68 in 2010 to 49 in 2011.
Also, please explain why did the occupancy rate decreased from 52.7% in 2009 with 68 beds to 47.7% in 2011 with 49 beds?

Response
Baptist Rehabilitation – Germantown received CON approval to establish an 18 bed Skilled Nursing Facility in 2010. Since 1 bed is an Acute care bed, the total rehabilitation unit became 49 beds. (68-1-18= 49)

The occupancy rate of rehabilitation services has been effected by the change in settings that are qualified by CMS for reimbursement for certain types of conditions. MedPac suggests that some of the growth in total rehabilitation days may be explained by a shift in the site of care from inpatient rehabilitation facilities (IRFs) to SNFs. The feasibility of provider settings, including IRFs and SNFs continues to be effected by changes in payer policies. Refinements in the policies from the Centers for Medicare and Medicaid Services continued with some taking effect in January 2010.

As presented in this CON application, the correct setting is essential to providing appropriate care. This application will improve the utilization of existing beds by making them more effectively able to accommodate compliant rehabilitation patients.

13. Section C, Economic Feasibility, Item 4 (Historical and Projected Data Chart

The HSDA is utilizing more detailed Historical and Projected Data Charts. Please complete the revised information Historical and Projected Data Charts provided at the end of this requests for supplemental information. Please note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should also include any management fees paid by agreement to third party entities not having common ownership with the applicant. Management fees should not include expense allocations for support services, e.g., finance, human resources, information technology, legal, managed care, planning marketing, quality assurance, etc. that have been consolidated/centralized for the subsidiaries of a parent company.

Why is Cafeteria Revenue included in the Projected Data Chart? Are these charges separate from the per diem charges?

The applicant has submitted a Historical Data Chart that includes outpatient and inpatient charges. Please submit a Historical Data Chart that only includes inpatient rehab charges for the past three years. This will enable a comparative analysis of the Historical Data Chart to the Projected Data Chart. In the Historical Data Chart please specify "B.4 Other Operating Revenue" and "D.8 other expenses". Please use the revised HSDA Historical Data Chart included at the end of this supplemental.

Response:
Cafeteria revenue reflects non-patient purchases and is not part of patient charges.

Both historical and projected are provided in the revised charts as requested.

14. Section C, Economic Feasibility, Item 6.A.

Please indicate the current and proposed charges. Also, please compare your average charge to several other freestanding rehabilitation hospitals in Tennessee.

Response:
The average charges for 2010 and 2011 are shown below along with the projected average charges for Year 1 and Year 2 after implementation of the proposed new Rehabilitation Hospital:

Comparison of historical and projected charges

Year	Gross Inpatient Charges	Gross Adjustments	Patient Days	Gross Charge/ Day	Net Rev/ Day
2010	$27,084,006	$16,094,386	10,290	$2,632	$1,068
2011	$27,202,752	$13,924,713	8,819	$3,085	$1,506
Year 1	$31,374,124	$18,290,235	11,095	$2,828	$1,179
Year 2	$43,373,988	$24,975,278	15,006	$2,890	$1,226

Charge comparisons to several other freestanding rehabilitation hospitals are shown in the following:

2011 Charge Comparison Source Hospital Joint Annual Reports and CN#1208-037

Facility	Gross Inpatient Charges	Gross Adjustments	Patient Days	Gross Charge/ Day	Net Rev/ Day
Baptist Rehab-Germantown	$27,202,752	$13,924,713	8,819	$3,085	$1,506
HealthSouth Memphis	$43,818,888	$18,794,949	19,529	$2,244	$1,281
Healthsouth Memphis North	$25,252,390	$6,830,021	13,657	$1,849	$1,349
The MED CN#1208-037			6,990	$4,446	$706
Vanderbilt Stallworth	$58,324,011	$32,658,946	22,180	$2,630	$1,157
HealthSouth Chattanooga	$22,988,928	$8,296,995	12,983	$1,771	$1,132

15. Section C, Economic Feasibility, Item 9

Please provide the most recent payor mix available of some other freestanding rehabilitation hospitals in the State.

Payor mix from free standing rehabilitation hospitals in the state

Source : 2011 Joint Annual Reports for Hospitals

Hospital Days	1	2	3	4	5	Days %	1	2	3	4	5
Self Pay	0	13	31	1	402		0.00%	0.10%	0.14%	0.01%	4.56%
Blue Cross/Blue Shield	772	454	3,232	398	939		3.95%	3.33%	14.57%	3.07%	10.65%
Champus/TRICARE	27	0	304	0	99		0.14%	0.00%	1.37%	0.00%	1.12%
Commercial	8	2,246	4,021	1,518	1,166		0.04%	16.46%	18.13%	11.69%	13.22%
Cover TN	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Cover Kids	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Access TN	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Medicaid/Tenncare	341	141	681	273	151		1.75%	1.03%	3.07%	2.10%	1.71%
Medicare-Total	13,782	10,643	13,396	10,629	5,888		70.57%	77.98%	60.40%	81.87%	66.76%
Medicare Managed Care	0	0	2,445	141	0		0.00%	0.00%	11.02%	1.09%	0.00%
Workers Compensation	228	0	515	37	174		1.17%	0.00%	2.32%	0.28%	1.97%
Other	4,371	152	0	127	0		22.38%	1.11%	0.00%	0.98%	0.00%
Total	19,529	13,649	22,180	12,983	8,819		100.00%	100.00%	100.00%	100.00%	100.00%

Hospital Legend for Above

HealthSouth Memphis	1
Healthsouth Memphis North	2
Vanderbilt Stallworth	3
HealthSouth Chattanooga	4
Baptist Rehab-Germantown	5

Hospital Admissions/Discharges	1	2	3	4	5	Admits	1	2	3	4	5
Self Pay	0	1	3	1	22	Disch	0.00%	0.10%	0.18%	0.10%	3.51%
Blue Cross/Blue Shield	57	33	225	37	64	%	3.61%	3.24%	13.25%	3.60%	10.22%
Champus/TRICARE	2	0	22	0	9		0.13%	0.00%	1.30%	0.00%	1.44%
Commercial	1	119	290	120	78		0.06%	11.69%	17.08%	11.68%	12.46%
Cover TN	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Cover Kids	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Access TN	0	0	0	0	0		0.00%	0.00%	0.00%	0.00%	0.00%
Medicaid/Tenncare	30	12	36	20	6		1.90%	1.18%	2.12%	1.95%	0.96%
Medicare-Total	1,118	838	1,088	834	442		70.80%	82.32%	64.08%	81.21%	70.61%
Medicare Managed Care	0	59	213	13	0		0.00%	5.80%	12.54%	1.27%	0.00%
Workers Compensation	19	0	34	3	5		1.20%	0.00%	2.00%	0.29%	0.80%
Other	352	15	0	12	0		22.29%	1.47%	0.00%	1.17%	0.00%
Total	1,579	1,018	1,698	1,027	626		100.00%	100.00%	100.00%	100.00%	100.00%

Hospital Legend for Above	
HealthSouth Memphis	1
Healthsouth Memphis North	2
Vanderbilt Stallworth	3
HealthSouth Chattanooga	4
Baptist Rehab-Germantown	5

16. Section C, Contribution to Orderly Development, Item 1

Are you able to document interest from any of the hospitals in your proposed service area regarding the development of transfer agreements?

Response:
Baptist Rehabilitation -Germantown currently has transfer agreements with other hospitals within the Baptist System and with Methodist Germantown Hospital. The new hospital is anticipated to have similar agreements but formal interest has not yet been established.

The current agreements are for transferring patients who need more medical assistance than is available at the originating hospital. As demonstrated by the assessment of need related to BMH-Memphis and BMH-Collierville, the primary source of admissions to Baptist Memorial Rehabilitation Hospital is anticipated to be from acute hospitals within the Baptist Memorial Health Care system.

SUPPLEMENTAL- # 1
December 27, 2012
2:41pm

AFFIDAVIT

2012 DEC 27 PM 2:47

STATE OF TENNESSEE

COUNTY OF SHELBY

NAME OF FACILITY: Baptist Memorial Rehabilitation Hospital

I, ARTHUR MAPLES, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Arthur Maples, Dir Strategic Analysis
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 27th day of December, 2012, witness my hand at office in the County of Shelby, State of Tennessee.

Paulette E. Kearney
NOTARY PUBLIC

My commission expires My Comm. Exp. August 21, 2016.

PAULETTE E. KEARNEY
STATE OF TENNESSEE NOTARY PUBLIC
SHELBY COUNTY

HF-0043

Revised 7/02

2012 DEC 10 AM 9 30

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the The Commercial Appeal (Name of Newspaper) which is a newspaper of general circulation in Shelby (County), Tennessee, on or before December 10 (Month / day), 2012 (Year), for one day.

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This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: Baptist Memorial Rehabilitation Hospital, G.P., a general partnership consisting of Baptist Memorial Health Services, Inc., an affiliate of Baptist Memorial Health Care Corporation and CRH of Memphis, LLC, an affiliate of Centerre Healthcare Corporation

with an ownership type of partnership and to be managed by: CHC Management Services, LLC intends to file an application for a Certificate of Need

to establish a rehabilitation hospital consisting of 49 beds. The hospital will be located in approximately 59,400 sq ft of space to be constructed at 1238 and 1280 South Germantown Parkway, Germantown Tennessee 38138. The location is close to the intersection of Germantown Parkway and Wolf River Boulevard in Germantown, Tennessee. Simultaneously with the implementation of the new hospital, Baptist Rehabilitation Hospital- Germantown would delicense the 49 bed Rehabilitation unit located at 2100 Exeter Road Germantown, Tennessee 38138 which is approximately 2.5 miles from the new site. The project does not involve the addition of beds or any other service for which a certificate of need is required. The estimated project cost is $33,167,900.

The anticipated date of filing the application is: December 14, 2012

The contact person for this project is Arthur Maples (Contact Name) Dir. Strategic Analysis (Title)

who may be reached at: Baptist Memorial Health Care Corporation (Company Name) 350 N. Humphreys Blvd (Address)

Memphis (City) TN (State) 38120 (Zip Code) 901 / 227-4137 (Area Code / Phone Number)

Arthur Maples (Signature) 12/7/2012 (Date) (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

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The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

==========

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
Division of Policy, Planning and Assessment
615-741-1954

DATE: February 28, 2013

APPLICANT: Baptist Memorial Rehabilitation Hospital
1238 and 1280 South Germantown Parkway
Germantown, Tennessee 38138

CON# 1212-061

CONTACT PERSON: Arthur Maples
Director of Strategic Analysis
50 Humphreys Boulevard
Memphis, Tennessee 38120

COST: $33,167,900

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Health Statistics, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's Health: Guidelines for Growth, 2000 Edition*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:

The applicant, Baptist Memorial Rehabilitation Hospital, G.P., located in Germantown (Shelby County), Tennessee, seeks Certificate of Need (CON) approval to establish a rehabilitation hospital consisting of 49 beds that will be located in approximately 59,400 square feet of space at 1238 and 1280 South Germantown Parkway in Germantown, located approximately 2.5 miles from the present location. Simultaneous with the implementation of the new hospital, the applicant will de-license the 49 bed (all private rooms) rehabilitation unit located at 2100 Exeter Road in Germantown, which is approximately 2.5 miles from the new hospital site. The project does not involve any addition of beds or any other service for which a CON would be required.

The hospital will be designed to accommodate specialized programs for stroke and neurological disorders. The project involves approximately 59,400 square feet with a construction cost of $15,400,000. The cost per square foot is estimated to be $259.66 per square foot. The applicant compared costs with approved CONs from years 2009 through 2011 in Figure B.II.a on page 9 of the application.

The new hospital will be owned and operated by the partnership formed by an affiliate of Baptist Memorial Health Care and an affiliate of Centerre Healthcare. Baptist Memorial has a 55% ownership interest and Centerre Healthcare completes the additional 45% interest. A Board of Directors comprised of both parties will govern the operations of the new hospital. A third party developer or Real Estate Investment Trust (REIT) will purchase/develop the land and building and lease it back to the joint venture. At the request of HSDA, the applicant provides charts of the organizational structure of the joint venture and the relationship between Centerre Healthcare in Supplemental 1, pages 3 and 4.

The total estimated project cost is $33,167,900 and will be financed through cash reserves. The land and building will be leased back to the joint venture by the aforementioned. The applicant provides documentation in Economic Feasibility 2 (E) and Economic Feasibility 2 (F) of the application.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition*.

NEED:

The applicant's service area is Fayette, Shelby and Tipton counties, with Shelby County representing 70% of the service area's population.

Service Area Total Population Projections for 2013 and 2017

County	2013 Population	2017 Population	% Increase/ (Decrease)
Fayette	39,818	41,841	5.1%
Shelby	956,126	983,298	2.8%
Tipton	63,857	67,365	5.5%
Totals	**1,059,801**	**1,092,504**	**3.1%**

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

Service Area Age 65 and Older Population Projections for 2013 and 2017

County	2013 Population	2017 Population	% Increase/ (Decrease)
Fayette	5,960	7,093	19.0%
Shelby	103,296	118,044	14.3%
Tipton	7,541	8,748	16.0%
Totals	**116,797**	**133,885**	**14.6%**

Source: *Tennessee Population Projections 2000-2020, February 2008 Revision,* Tennessee Department of Health, Division of Health Statistics

This application replaces a 49 bed inpatient rehabilitation unit at Baptist Memorial with a new 49 bed inpatient rehabilitation facility that is ADA compliant, has private rooms, and has state-of-the-art equipment and facilities. The new facility will allow for more effective capacity (all private rooms), establish a "Center of Excellence" for the Memphis area, and better serve the community by creating specialized programming for stroke, neurological disorders, and brain injury patients.

The increased capacity and specialized programming (allowing for gender issues, disease control, etc. by having private rooms) will strengthen the post-acute continuum and maintain highly acute patient populations. This project, by enhancing the ability to care for medically complex patients, reduces the likelihood of readmissions and reduces the overall cost of care.

In addition to the change from semi-private to all private rooms, the new facility is needed to better align patient services with patient needs and expectations and to support utilization of the entire 49 bed compliment of the inpatient rehabilitation facility (IRF). The entire hospital is designed to meet the needs of persons with a disabling condition by having all ADA compliant rooms.

The activities of daily living (ADL) space and private rooms allow family members the ability to practice safe techniques such as bathing, transferring from bed to chair, etc. prior to taking the patient home. This reinforces family learning and helps with a successful discharge to home. The planned IRF also has a mobility courtyard which simulates curbs, rough and smooth terrain and various depths of steps. Practice on these skills allows the patient to be mobile in the community. A large therapeutic gym space allows patients to receive their therapeutic exercises and training in an environment where they are able to see other patients with disabilities making progress which helps support progress toward their treatment goals. In general, private treatment rooms allow for a more flexible environment and the large common areas will allow for improved socialization skills.

A specialized Stroke/Neurological Unit (24-26 beds) will be established to meet the needs of the approximately 3,000 MDC 1 (Diseases and Disorders of the Nervous System) patients being discharged by Baptist Memorial and other hospitals into a safe and secure environment. This is a specialized, self-contained unit that includes dedicated therapy and treatment space. By following the Medicare (CMS) 60% Rule and CMS's 13 criteria (see Exhibit C: Need.6); CMS has specifically encouraged providers to assume responsibility for these types of patients.

The applicant expects to achieve Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation for stroke and brain injuries. CARF is an independent, non-profit organization that focuses on advancing the quality of services and evaluating healthcare providers' commitment to continually improving services and serving the community. The applicant believes that achieving CARF accreditation for these specialties is part of their mission to enhance the specialized programs that Baptist provides the Memphis and Shelby County community and establish a "Center of Excellence" that is not currently available to the community.

Currently there are five hospitals in Shelby County with certified inpatient rehabilitation beds, including Baptist Memorial-Germantown. These five hospitals have a total of 218 beds. This project does not add beds and will serve the same service area. Therefore, this project will not impact other facilities in the service area.

TENNCARE/MEDICARE ACCESS:
The applicant participates in both the Medicare and TennCare programs, and has contracts with BlueCross/BlueShield BlueCare, TennCare Select, and AmeriChoice.

TennCare Enrollees in the Proposed Service Area

County	2013 Population	TennCare Enrollees	% of Total Population
Fayette	39,818	5,631	14.1%
Shelby	956,126	230,053	24.1%
Tipton	63,857	11,473	18.0%
Total	**1,059,801**	**247,157**	**23.3%**

Source: *Tennessee Population Projections 2000-2020,* February 2008 Revision Tennessee Department of Health, Division of Health Statistics and *Tennessee TennCare Management Information System, Recipient Enrollment,* Bureau of TennCare

The applicant estimates the first year Medicare revenue to be $18,864,414 or 60% of total gross revenues. TennCare/Medicaid revenues are estimated to be $1,257,628 or 4% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:

In the Project Costs Chart, the total project cost is $33,167,900, which includes $49,500 for legal, administrative, and consultant fees; $484,217 for a contingency fund; $2,303,000 for fixed equipment; $30,286,183 for the facility (lease costs over the initial term of lease); and $45,000 for CON filing fees.

In the Historical Data Chart located in Supplemental 1, the applicant reports 626/8,819, 1,043/12,693, and 803/10,290 discharge days for 2009, 2010, and 2011 with gross operating revenues of $32,106,607, $28,705,430, and $28,615,018 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $9,317,089, $13,113,525, and $14,690,305 each year. The applicant reported management fees paid to affiliates of $1,248,050, $1,360,921, and $1,443,235 each year. The applicant reported a net operating income/ (loss) of ($4,687,595) $384,132 and $2,156,595 each year, respectively.

In the Projected Data Chart located in Supplemental 1, the applicant projects 785/11,095 and 1,061/15,006 inpatient discharges/inpatient days in years one and two with gross operating revenues of $31,507,256,and $43,467,170 each year, respectively. Contractual adjustments, provisions for charity care and bad debt reduced net operating revenues to $13,217,021 and $18,491,892 each year. The

applicant projects management fees paid to affiliates of $490,000 and to non-affiliates of $75,000 in year one and $76,500 and $935,980 in year two. The applicant projects a net operating income/ (loss) of ($375,997) in year one and $2,505,305 in year two.

The applicant projects a year one gross charge of $31,374,124 and 11,095 patient days, with a daily gross charge of $2,828, with a net charge of $1,179 per day. In year two, the applicant projects a year one gross charge of $43,373,988 and 15,006 patient days, with a daily gross charge of $2,890, with a net charge of $1,226 per day. The applicant compares its projected charges with those of other inpatient rehabilitation facilities in Supplemental 1, page 47.

The applicant considered renovation or additions to the current facility but decided the most feasible course of action was the relocation of existing IRF beds that will remain in the community, with services area matched to the needs of the area. The partnership formed by Baptist Memorial Health Care and Centerre Healthcare will offer inpatient rehabilitation services in a new state-of-the-art 49 bed freestanding facility with all private rooms.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

The new facility will continue the relationships throughout the Baptist healthcare system and with other providers in the community. Baptist Rehabilitation–Germantown has transfer agreements within the Baptist healthcare system and with Methodist Germantown Hospital.

The applicant believes the proposed new hospital will positively affect the health care system. The new private rooms will accommodate more patients effectively and efficiently without adding additional beds.

A specialized Stroke/Neurological Unit (24-26 beds) will be established to meet the needs of the approximately 3,000 MDC 1 (diseases and disorders of the nervous system) patients being discharged by Baptist Memorial and other hospitals into a safe and secure environment. This is a specialized, self-contained unit that includes dedicated therapy and treatment spaces.

The applicant provides the year one and two staffing pattern for the proposed hospital on page 43 of the application.

Baptist Memorial Health Care Corporation is a strong supporter of educational opportunities throughout the region. Baptist Memorial College of Health Sciences was chartered in 1994 as a specialized college offering baccalaureate degrees in nursing and allied health sciences as well as providing continuing educational opportunities for healthcare professionals.

The applicant is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by Joint Commission, and will seek CARF accreditation. The most recent licensure survey occurred on 8/24/04 and no deficiencies were cited.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's Health: Guidelines for Growth, 2000 Edition*.

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   Not applicable.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      Not applicable.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

      Not applicable.

This application represents simply a relocation of existing inpatient rehabilitation services. The proposed site is only 2.5 miles from the current location in Germantown. The IRF will be no less conveniently accessible to the population of the service area than the existing inpatient rehabilitation facility.